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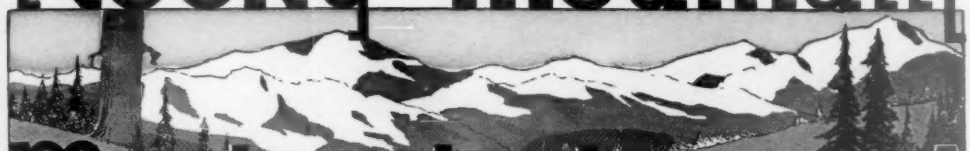

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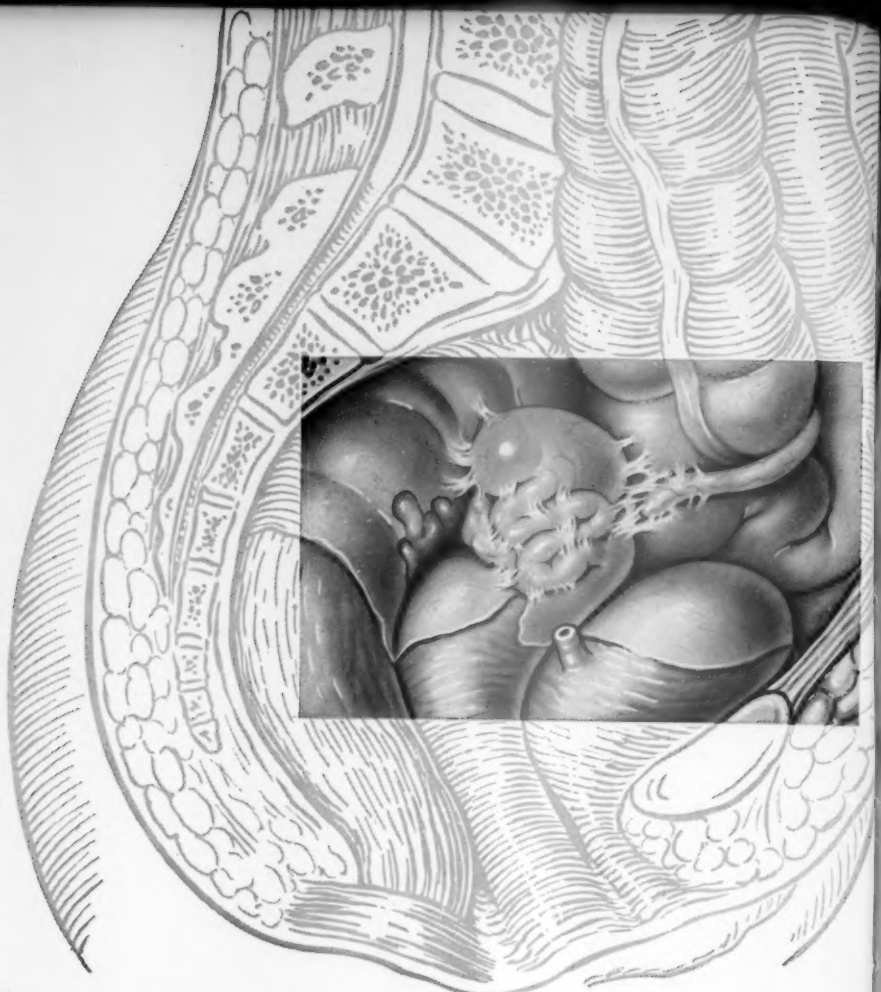

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1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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VOLUME 49 NUMBER 6

JUNE, 1952

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NEXT ANNUAL SESSION: STANLEY HOTEL, ESTES PARK, SEPTEMBER 9, 10, 11, 12, 1952.

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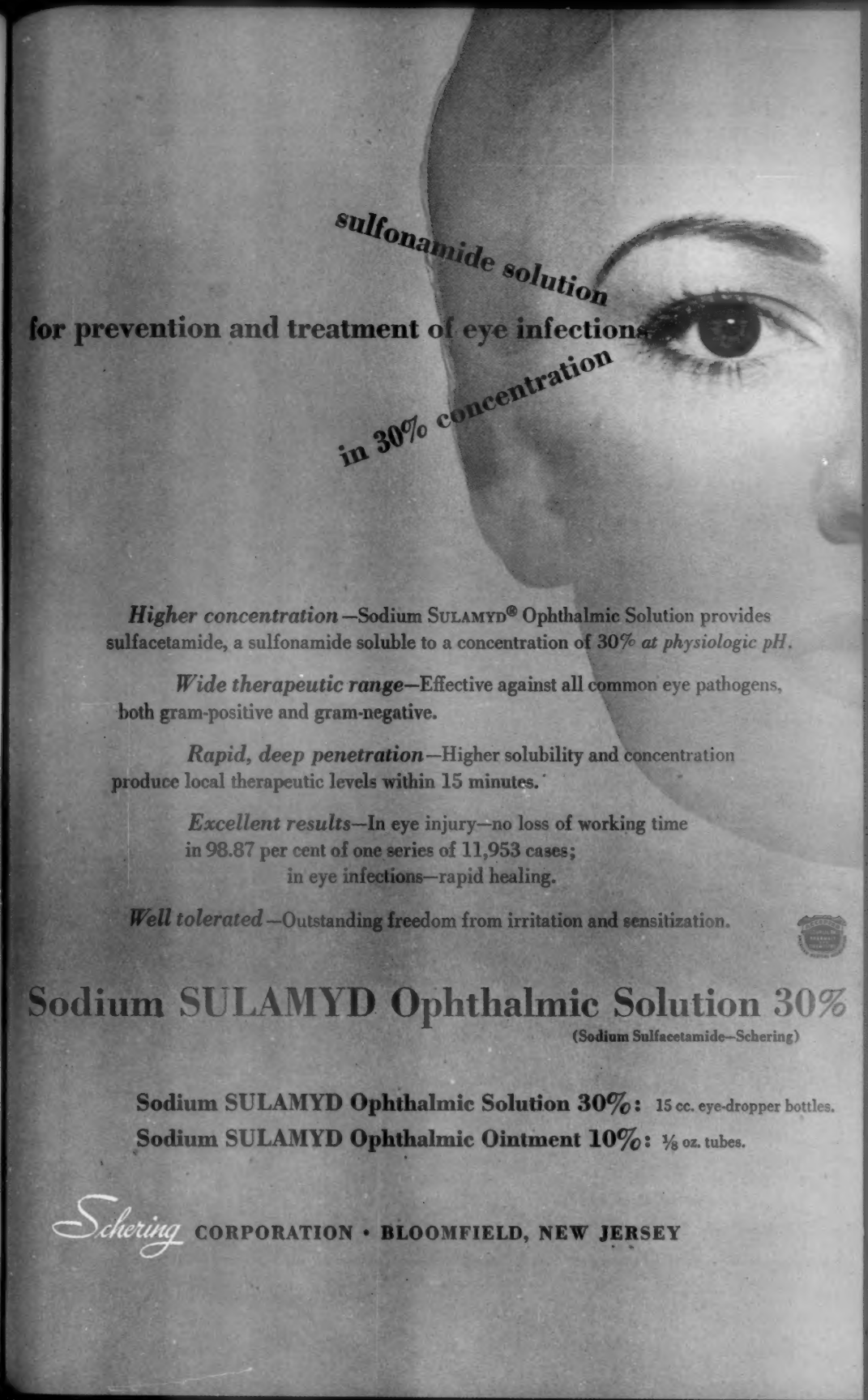

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THE UTAH STATE MEDICAL ASSOCIATION

NEXT ANNUAL SESSION, SALT LAKE CITY, SEPTEMBER 4, 5, 6, 1952

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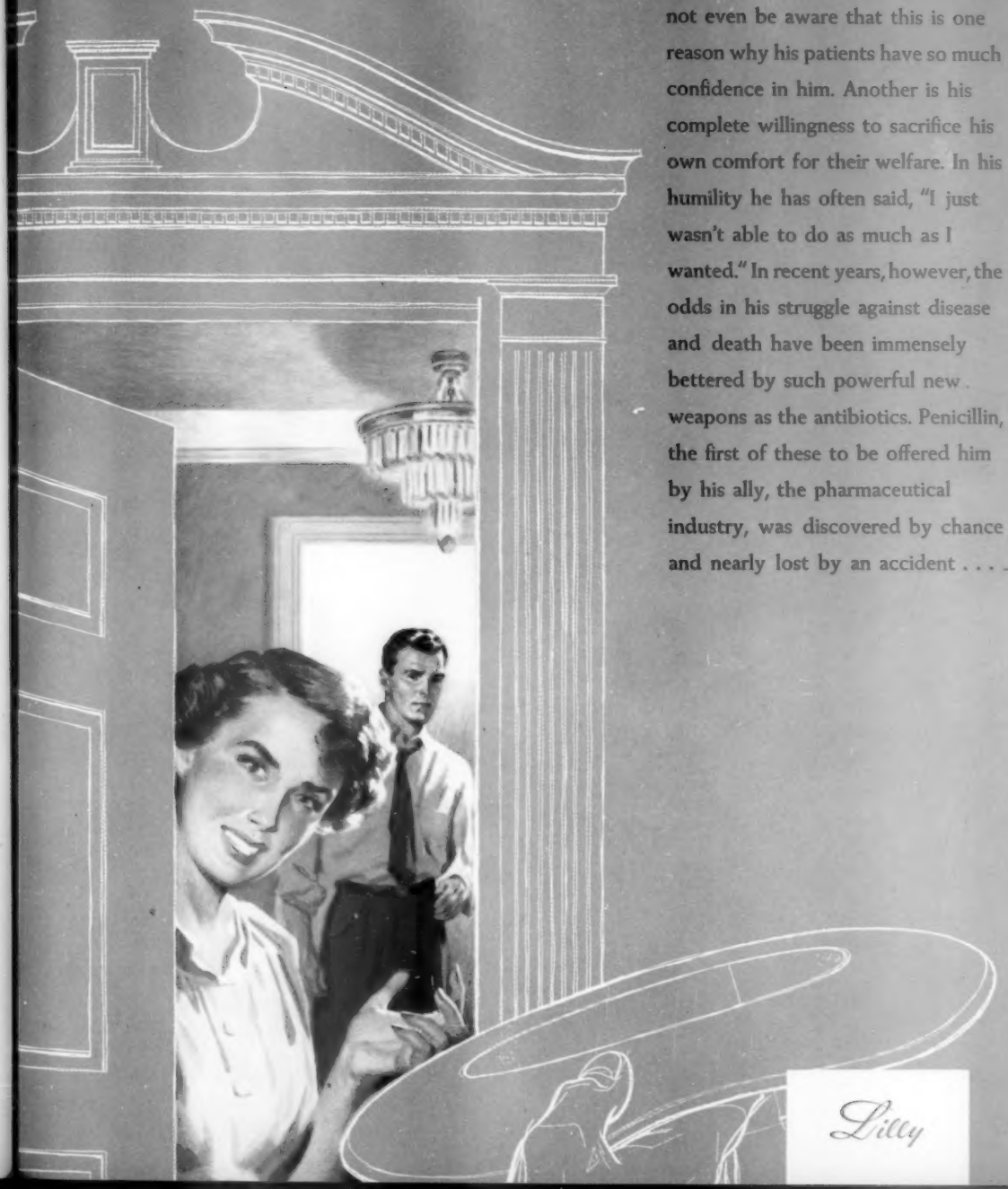
Resolutions: Sister Mary Raymond, Mercy Hospital, Denver; James A. Harrison, Community Hospital, Boulder.

"Please come in, Doctor Harris ...
... Now everything is going to be all right"



Dr. Harris is a modest man. He may not even be aware that this is one reason why his patients have so much confidence in him. Another is his complete willingness to sacrifice his own comfort for their welfare. In his humility he has often said, "I just wasn't able to do as much as I wanted." In recent years, however, the odds in his struggle against disease and death have been immensely bettered by such powerful new weapons as the antibiotics. Penicillin, the first of these to be offered him by his ally, the pharmaceutical industry, was discovered by chance and nearly lost by an accident . . . →

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Rocky Mountain Medical Journal
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JUNE
1952

Editorial

This Campaign Is Different!

FUND-RAISING CAMPAIGNS, like the poor, are with us always nowadays. If it isn't the Community Chest, it's the Red Cross, the March of Dimes, Polio, Cancer, or any of a dozen others. To most of them we give a large or small amount. To some of them we say "No," and we wonder why some local or larger branch of government does not take over the load. On careful second thought, all of us should realize that such faulty first-blush wishes that "government" would do it have caused much of our tax inflation and burgeoning bureaucracy in recent years.

Which leads us to the thought of a current campaign that is different. It is not charity as we usually think of the word. And it is not a local or national fund-raising campaign in which physicians should join as just another duty to be shouldered alike by all good citizens.

This is one in which we as doctors should, can, and must lead the way.

It is the American Medical Education Foundation.

This spring and early summer committees throughout organized medicine, and in every one of our Rocky Mountain states, will be seeking our contributions to the Foundation. How much each of us can give is a personal matter. That every one of us should give as much as we reasonably can is really beyond question. And that many more of us have given than currently shows on the record is also beyond question. Let's see that the record is cleared this year.

Further argument about the needs of our medical schools is unnecessary. The alternative of federal subsidy with its bureaucratic controls is well understood and we are thankful that most medical school deans have now reversed themselves and prefer voluntary and state support to any form of federal "aid." So, the Foundation must succeed.

It matters not whether we give funds to the Foundation for equal distribution among all medical schools, or earmark our donation to the medical school of our personal choice. It does not matter, either, if we prefer to give to or through our own alumni organization or independent foundation whose funds assist our own alma mater or any other. But it does matter to get our gifts on record with the Foundation, through our county or state Foundation chairman. In one way or another, every one of us wants to take part. Many, perhaps most, of us already do. To inspire others after we have led and shown the way, to inspire industry, business, great philanthropy and the allied professions to add their larger funds to the growing total, let's be sure that we do not hide our light under that proverbial bushel.

If you do not know who your local or state chairman is, ask your County Medical Society Secretary. Make the largest donation you can, through whatever agency aiding medical schools you choose, then be sure that it is recorded with your Foundation chairman.

Yes, this campaign is different; it's got to be!

Cancer of the Head and Neck

OUR PROFESSION has no reason to be proud of results from its efforts to cure cancer involving the head and which has extended into glands of the neck. Some statistical compilations indicate that as few as 15 per cent of all cases are permanently cured. Radiologists and surgeons represent different "camps." Some in each group contend that the other occupies a subsidiary position. We believe that each has its place; superior results will follow a careful weighing of respective merits and limitations, and cases should be considered in the light of both. Isolated involved glands that can be completely excised may be most promptly disposed of by surgery, with less danger to surrounding tissues. Squamous cell carcinoma in lymph nodes is more resistant to irradiation, as a rule, than the primary site. Some of our colleagues state that external irradiation has no place in treatment of metastatic neck glands, and some are not equipped to perform interstitial irradiation.

Impressive statistics are presented by Dr. Charles Martin of Dallas, Texas. He treats neck glands with radium needles, working in many cases in conjunction with surgical confreres. He contrasts his record of 70 per cent cures after five years with those of Dr. Hayes Martin of New York City—51.1 per cent following surgical dissection. The former claims that most patients in his remaining 30 per cent of cases may still be subjected to block dissection when indicated, and the prognosis is then as good or better for the use of irradiation. Available statistics upon surgical treatment other than those of Dr. Hayes Martin show five-year cures of 11 to 39 per cent, averaging about 24 per cent on operable cases. All cases, including Grade IV and inoperable cases, are included in the series which indicate that rate of cure can be as low as 15 per cent.

Obviously we have much to learn regarding cancer and, in view of the present national financial drive, it is now appropriate to give it even more than our usual attention. No visible or palpable tumor need be blindly treated without definite diagnosis, since adequate diagnostic aids are now available. When diagnosis positively indicates cancer, "flirtation" with the tumor with either surgery or irradiation is absolutely contraindicated. Then is the time to roll in our heavy artillery. Let us order and apply that which stands the greatest chance of improving the statistics. Look again at the above figures; it is up to our profession to bring forth steady progress in our conquest of the disease.

❦ ❦ ❦

A Timely Objective

WE HAVE no way of knowing exactly how many physicians in the Rocky Mountain region went to the polls in the last Presidential election, but we do know that in the recent past doctors have not distinguished themselves in the matter of registration and voting.

Since 1948 the medical profession has shown marked improvement in its voting performance and its interest in public affairs. However, we still have a long way to go. The objective in 1952—a critical year of decision if there ever was one—should be nothing less than a 100 per cent registration and voting record by physicians.

Ordinarily, only about half of the eligible voters in this country exercise their privilege of voting in national elections. It is up to physicians to set an example and lead the way in the effort to improve that record. The more people who use that privilege, the longer it will last. Do your part: first, Register; then, Vote. And of equal importance, see that your family does the same.

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"I THINK we have more machinery of government than is necessary, too many parasites living on the labor of the industrious."—**Thomas Jefferson.**

Original Articles

PRESIDENTIAL ADDRESS*

COY S. STONE, M.D.
HOBBS, NEW MEXICO

For the past several years the doctor has been viewing himself and his profession critically from a new angle. While doctors have always given freely of themselves for the good of their fellowmen, the profession nevertheless has stayed in a sort of a shell of scientific absorption.

The doctor is now beginning to peer out of that shell.

Medicine has commenced to abandon its old position of sitting on the sidelines while members of other groups pull the economic and political strings that chart our nation's course.

We doctors are developing economic and political awareness, which I, being an optimist, believe has not come too late.

For the past several years most discussions at state medical meetings have centered around the evils of socialized medicine and compulsory health insurance and around public relations problems, with great emphasis being placed on the fact that the medical profession is merely being used by the social planners as an entering wedge for national socialism.

Gentlemen, I wish to state that the door to socialized medicine has already been wedged open by our Veterans' Administration program.

Almost any veteran can get free medical aid at Veterans' Administration Hospitals whether his illness or injury was caused by military service or not. On March 30, 1952, the front page of one of our large newspapers in the Southwest came out with an article entitled: "Veterans' Administration Hospitals Offer Free Medical Rides." The newspaper article described medical services offered to veterans in a large Texas city. "Eighty per cent of the patients," it revealed, "cannot trace their disability to military service."

On our own side of the ocean, medicine has not been directly socialized. But an expanding program of federal medical care is tending to socialize our country that up to now has been committed to the support of free medicine.

Quoting from the bi-partisan Hoover Commission:

> "Our federal government is by far the largest employer of doctors and the biggest operator of hospitals in the land. Required to provide some form of free medical care for twenty-five million people, Uncle Sam spends $2 billions a year on federal medical service."

And, by far, the largest eligible group is veterans. I have recent advice from the Washington office of the A.M.A. that there are now almost twenty million veterans of our country's wars.

New ones are returning from honorable and hazardous service every day. I am steadfast in my assertion that these men deserve the best that we can give them. To the veterans of all our wars the country owes a debt it can never repay. A little more than a generation ago this nation could look upon Europe's wars and its thousands of battle-maimed men with a sort of aloof compassion. But we have become a rather battle-scarred nation ourselves.

We know that we have the moral obligation to give every citizen, rich or poor, inhabitant of rural or urban area, the very best medical care within the limits of possibility. Have we additional obligations to veterans who saw arduous and honorable service?

It is my belief that we have. I believe that it is the overwhelming sentiment of the American people, and rightly so, that those who have become physically handi-

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capped as the result of such service should receive the finest medical attention—not only while in uniform but for the rest of their lives—and, that they should receive the same fine medical care for any complaints that might stem from service-connected disabilities. I further believe that such medical care should extend to chronic illnesses and other serious and expensive medical requirements, whether service-connected or not, that exceed the veteran's reasonable ability to pay. I believe that such care should extend to any case involving a dispute as to whether the disability is service-connected or not—and that these medical services should be regarded as the right of these men, and not as a condescending gratuity.

But the current program of dispensing medical care to veterans, rich and poor, for non-service-connected disabilities, should be reviewed in a critically dispassionate manner.

What is good for veterans is whatever is good for the entire country. Veterans pay the same taxes and have the same stake in the future of this country as have non-veterans. It is no more to their interest that American medicine be socialized through federalization, or that the veteran's tax dollar be bandied about, than it is to the interest of those who did not see service.

Dr. H. H. Shoulders of Tennessee in his provocative article in "GP" of The American Academy of General Practice in April, 1952, has vividly called to our attention the two movements sponsored by the American Legion which are in conflict with each other:

> "One of these movements is to promote Americanism. It is called 'A Crusade for Freedom.' The other movement is to build a government system of medical care which can destroy the freedom in our civilian system of medical care by the process of encroachment. This government system of medical care already is one of the largest systems in the world. Without a doubt, it is the most potent threat to our civilian system of medical care that exists today. This is true for one important reason:
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> "Our civilian system cannot successfully compete with a government system for money, for personnel, for material, and for equipment. The federal purse apparently is unlimited. The civilian purse is limited, very greatly by federal taxation."

At the present time we are urged to favor appropriations for the further expansion of facilities for veterans' care, when the truth of the matter is that if only service-connected disabilities were being cared for the existing facilities are more than adequate at the present time. Since some 80 per cent of admissions to Veterans' Administration hospitals at present are for non-service-connected disabilities, surely not all of these veterans are indigent. That many of them are not is proven by the fact they carry commercial health and accident insurance policies. These claims are in direct competition to our private hospitals and medical practitioners in the same community.

At present, there are 4,131 full-time physicians in Veterans' Administration hospitals.

To get some idea as to the gigantic scope of the medical care program of the Veterans' Administration, let's look at some figures which have been checked by our American Medical Association office in Washington, D.C., and which were carefully prepared by consultation with the appropriate governmental authorities.

As of January 31, 1952, there were 115,812 beds in operation in Veterans' Administration hospitals. There were 153 Veterans' Administration hospitals in operation, ninety-nine for general medicine, twenty for tuberculosis, and thirty-four for neuro-psychiatric cases. As to new hospitals being built, at present there are twenty-four under construction, and eleven new hospitals were opened last year. As to admissions in Veterans' Administration hospitals, there were 577,715 in the fiscal year of 1951.

To get some idea as to the expense: Congress appropriated $676,288,080 for medical, hospital and domiciliary services of the Veterans' Administration for 1952. The last Congress appropriated $350,000,000 for additional Veterans' Administration hospitals and reduced the appropriations for civilian hospital construction from $150,000,000 to $82,750,000. See the article in "GP."

Sixty-six medical schools lend their prestige and skill to the operation and expansion of the present Veterans' Administra-

tion program. Seventy-two Veterans' Administration hospitals have been approved for intern and resident training. There are 1,988 part-time residents, thirty-eight full-time residents, and fifty-six part-time interns receiving training at the present time in Veterans' Administration hospitals. Dr. C. F. Bayer, Chairman of the Special Veterans' Administration Board, testified before the Senate Committee on Government Operations that the Veterans' Administration had 475 vacancies for physicians. Dr. Bayer said that the Veterans' Administration has the funds for salaries but has been unable to fill the posts.

As of February 15, 1952, 71,572 veterans were awaiting admission to Veterans' Administration hospitals. Of these, 21,391 were non-service-connected, and 12,805 of the 21,572 were N.P. cases. In other words, only 181 veterans out of the 21,572 had service-connected disabilities, which leads us to believe that a much higher figure than 80 per cent would be more correct for the percentage of non-service-connected disabilities being treated in our Veterans' Administration hospitals.

The A.M.A., through its House of Delegates, has up to the present time refused to resist this situation. Why? Since the A.M.A. has endorsed the insurance principle and has on many occasions deplored the establishment of tremendous federal bureaucracies, since the A.M.A. has consistently advocated a free choice of physicians, one can only speculate as to why it should condone such a program. This, gentlemen, is socialism.

This does not allow for free choice of physicians and it builds up a huge bureaucratic regime to control the practice of medicine. So far as the effect is concerned, great numbers of veterans hardly can be the cause of political expediency since where there are twenty million people with veteran status today, there may well be fifty million within a few years to come. Apparently there are those who control rather large delegations to the House of Delegates of the A.M.A. who have been offered "something" which alters their views regarding the principle upon which this Association waged such a successful campaign against compulsory health insurance.

Many of our new veterans' hospitals have been established near medical schools. The hospitals offer research programs, staffing and supervision work. Such hospitals, under the Deans' Committee, have had considerable to do with the lack of opposition in the House of Delegates. This, I'm afraid, has led to much of the unwarranted care of veterans with non-service-connected disabilities. Proposals for remedying this situation have been made repeatedly in the House of Delegates of the A.M.A. and just as often had no support. Instead, intense criticism by proponents of the plans has been heard.

New Mexico is a small state and is numerically unimportant. But so far as representation of the House of Delegates in the A.M.A. is concerned, it has a voice. And I believe that this voice should be used to bring our Association to a realization of its obligation to uphold the principles for which it previously has fought.

R. Cragin Lewis, in an article reporting the events and the discussion at the A.M.A. delegates' session at Los Angeles, said a typical comment at that session was, "We've got socialized medicine right now within the framework of the Veterans' Administration, and the framework keeps getting larger." Now let us look at this framework of the Veterans' Administration and see how it operates.

Existing legislation, in essence, provides that the Administrator of Veterans Affairs is authorized under certain limitations to furnish hospitalization and treatment to honorably discharged veterans who are unable to defray the necessary expenses of such hospitalization. The law further provides that a statement of the applicant under oath shall be accepted as sufficient evidence of inability to defray the necessary expenses.

As I have said, I have no quarrel with the furnishing of medical care to veterans who are unable to pay for the care they need. But I regard as ill-founded legislation that portion of the statute which reads: "The statement under oath of the applicant

on such form as may be prescribed by the Administrator of Veterans Affairs shall be accepted as sufficient evidence of inability to defray expenses." No means test is provided the Administrator of Veterans Affairs under this law. The "Tennessee Plan," which you all have read, proposes a provision for treatment by Veterans' Administration hospitals of certain non-service-connected disabilities. A veteran's federal income tax return can be used as the means test. I can't think of anything wrong with such a means test, and it is my feeling that it should be written into law.

When we consider the expanded consciousness of our duty in these fields of politics and economics I like to start thinking first of the simplest and primary political duty—the duty of voting. This is an old topic, I know. But when we examine the statistics on how well that duty is carried out I believe it can bear repetition at any professional gathering, particularly the gathering of a profession faced with such pressing public issues. Gentlemen, we must meet these issues before it is too late!

Active citizenship starts with voting. No citizen would be willing that his right to vote should be abolished. But any time he fails to vote he abolishes it himself. Senator Fulbright of Arkansas, in commenting on our national apathy, has said, "too many people in our nation do not believe anything with conviction . . . the values of life which were clear to the Pilgrims and Founding Fathers have grown dim."*

It seems a curious thing that the larger and more complex our government has become, the less the responsibility the average individual has seemed to feel toward it. Probably, the average voter has felt that with the expansion of functions, the swelling of the bureaucracy, the mounting of the national deficit figures, a measure of individual control over national destiny has slipped away. He is conscious of these things, but left rather dazed and wondering at what one individual could do to return governmental affairs to a state in which he has more confidence. He wants to protect and improve his country. But it appears that his voice, if he raised it at all, would be drowned by those demanding special interests—that, or by plain bureaucrats who because of their astounding numbers always seem to him to be in the majority.

But I have said that I am an optimist. I believe that it is not too late for the government to be returned to the size and basis which this average voter can understand—the kind of government that secures to him the privileges and is dedicated to the purposes set forth in the Declaration of Independence.

No concept of our Founding Fathers ever dreamed a welfare state. Not only did they abhor the idea, they knew that their young nation could not afford it. They knew that no "free rides" by the government are really free.

This sound concept of economics and government stemmed from the economic realism of a country that had not grown fat enough to give anyone a free ride. But their greater conviction, born from their experience in launching the struggling young state, was to keep in view not the free ride, but the incentive of the free man.

I believe the average voter still thinks that way. Maybe for a time he ceased to think, or lost the trail. But this average voter—and I keep talking about him because I am one—is now gaining confidence. He is awakening to the role that he has as an individual. He is beginning to feel individually responsible for his government. From this feeling I believe better government is on the way.

The individual feels far more confident of results when he acts in concert with others than when he acts alone. The concerted action of groups imbued with the same ideals is the action, or the "pressure," if you wish, that can change the course of events. Actions of doctors working through their associations, not only on the national level but on the state, county and community level, will be effective if we keep at it.

One of the most pressing problems with which our profession and the nation at large is confronted is the financial support that is necessary for medical education.

We have made a start, but additional

*Ibid.

funds are absolutely necessary if our medical schools are to maintain their high standards. This support can come from only two sources—private enterprise or government. The American Medical Association has strongly opposed federal aid to medical education. The consequences of such a free ride are too easily foreseeable. But the problem has not yet been solved.

There are 466 doctors in private practice in the State of New Mexico. Of these, at the end of 1951, 418 were members of the State Society. But out of the 466 doctors, only twelve have contributed to the American Medical Educational Foundation. Gentlemen, I have no comment! These figures speak for themselves!

Dr. John W. Cline, President of the American Medical Association, in an address February 11, 1952, confidently predicted that 30 per cent more physicians will be graduated annually by 1960 than was the case in 1950.

Public health is primarily the responsibility of our profession. Everyone wants better medical care for the low-income groups and it falls to organized medicine to devise the best possible plan and one that will not put an end to free enterprise. In June, 1951, when President Truman dedicated a medical center at Bethesda, Maryland, he said: "Skyrocketing medical costs are pushing millions of Americans into the medically indigent class."

Gentlemen, we have an obligation to answer in an effective way the charges of those who claim that compulsory health insurance is necessary because adequate medical care is not within the economic reach of everyone. To this end, we as other societies have established a voluntary health insurance program. It guarantees not indemnity, but service to its contract holders for those types of illness which might be financially burdensome to low-income groups. This plan covers over 50,000 people in New Mexico at the present time, and it is growing. Recently it has been revised to offer better coverage to patients and benefits to physician members.

It has received financial help from the medical profession of the state which was interested and impressed with the necessity of providing such service to low-income groups. Supported financially at the start by some eighty members of our own Society, it has been sturdily backed by a majority of the members throughout its existence. It is extremely important that we continue to show in this practical way our belief in the American principle of allowing people to be responsible in a voluntary way for their own welfare.

This voluntary plan has been one of the finest and most important contributions this Medical Society has made toward preservation of the American Way of Life. It is my sincere belief that we can offer no more effective service than by continuing to support this—our plan—which offers medical care to people in low-income groups without government interference.

We cannot lapse from vigilant study and action. We must devote our energies to political matters as much as possible. As one writer said, "Either you run your own government or it will run you. It can be as good or bad as you, individually, permit it to be. Government is your responsibility, a direct or personal responsibility. You cannot delegate that obligation or pass it on to others."*

In our desire to cure the economic and political ills, I believe Dr. W. A. Bunten in his address in June, 1951, reflected our feeling that the practice of medicine still remains a profession, a calling, and not a business. Many sacrifices must be made. If it were not a calling, we would not work the long hours that we do.

In France, there is a monument to Pasteur and it has on it a brief inscription in French, which translated means,

"To cure sometimes.

To relieve often.

To comfort always."

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*Keeler, "Government Is Your Business," Doubleday & Co., Inc.

SENILITY AND SENESCENCE IN OPHTHALMOLOGY*

EDMUND B. SPAETH, M.D.
PHILADELPHIA

The first consideration is the social and economic side of this problem. A quotation from that book of Sir James Jeans, published posthumously in 1947, "The Growth of Physical Science," is relevant as an introduction: "We look on helpless while our material civilization carries us at breakneck speed to an end which no man can foresee or even conjecture. And the speed forever increases. The last hundred years have seen more change than a thousand years of the Roman Empire, more than a hundred thousand years of the Stone Age. This change has resulted in large part from the applications of physical science which, through the use of steam, electricity and petrol, and by way of the various industrial arts, now affects almost every moment of our existences. Its use in medicine and surgery may save our lives; its use in warfare may involve us in utter ruination. In its more abstract aspects, it has exerted a powerful influence on our philosophies, our religions, and our general outlook on life."

The problem of probable increasing pathology of senile degenerative types is important in a population which is also increasing in age. There is no doubt that this age increase in population must influence industrial medicine to a tremendous extent. The costs of living will be permanently raised, due to increased costs of insurance, of pensions, of Social Security and the many other less evident old-age charges. Insurance companies with their statistics, organizations and institutions studying social problems and others studying geriatrics all have charted this constant increase in longevity of the population to a rather astonishing exactness. Because of all factors which might be related to such a lengthened life span, increase of this problem of senility and of senescence will almost certainly continue and become a great sociological revolution. This must be studied by educational institutions, by commercial and financial departments and by governments at all levels, from the Federal down to the tiny village. As to the medical aspect of this, the ophthalmologist could be one of a group authoritative in observations and in opinions relative to this part of the problem, for the eye is one of the few portions of the body in which one may look directly into an organ of importance and draw conclusions. Furthermore the eye, as an entire organ, an entity with its complex anatomy, lends itself well to the microscopic study of normal tissue, of degenerative changes, and of all types of diseased conditions. As Adalbert Fuchs said, "It is possible, therefore, to observe not only organic, but also valuable clinical and diagnostic details. The examination of the eye-ground is more important in the diagnosis of general physical ailments and many phychic disturbances than is generally realized." Because of that the ophthalmologist should be of value in studying senescence.

Kornsweig recently analyzed the changes seen at postmortem study in 120 eyes as obtained from patients who died at an age between 70 and 90 years. These cases all had had clinical examinations prior to death, as well as pathological examinations of the eyes after autopsy.

The pathological changes which Kornsweig found are listed herein and those which are significant to the degenerative changes of old age will be discussed in greater detail. These histological findings were:

1. Cystic degeneration at the ora serrata.
2. Thickening of the arachnoid about the optic nerve.
3. Fibrosis and hyalinization of the ciliary muscle.
4. The development of hyaline bodies at the lamina vitreae.
5. Incipient cataract.
6. Sclerosis of the choroidal arteries.
7. Sclerosis of the central artery of the retina and its branches.
8. The deposit of pigment granules in the pectinate ligament.

*Read at the annual meetings of the Ogden Surgical Society, Ogden, Utah, May 23, 1951.

9. Sclerosis of the iris arteries, including the major arterial circle of the iris.

10. Proliferation of the pigment layer of the pars planum of the ciliary body.

11. Cystic separation of the nonpigmented from the pigmented epithelium of the pars planum.

12. Hyaline thickening of Descemet's membrane.

13. Hyalinization of the subsphincter tissues of the iris.

As one reviews these pathological findings, it is evident that several basic processes are significant. Outstanding are the changes in the blood vessels, sclerosis of the choroidal arteries and the central retinal artery and its branches, and sclerosis of the arteries of the iris. Clinically these arterial changes are known to be accompanied also by sclerotic and degenerative changes in the paralleling veins of the eyeball. Such peculiarly individual veins as the vortex veins of the eyeball and the origin of their blood supply in the choroidal venous circulation are also subject to extreme degrees of sclerosis.

Essentially senile changes in the arteries are fatty depositions in the intima. A similar fatty degeneration of the muscular coat of these areas develops—a degeneration of fibrous tissue—progressive hyalinization, and ultimately a vessel results which has been changed to a thick white chord, frequently with the lumen entirely absent. The changes which develop in the veins are rather similar, a thickening of the walls from connective tissue deposition, with the perivascular tissues showing fatty deposition.

The changes which occur in the capillaries are most significant, as Duke-Elder states: "Since these capillary changes are secondary to degeneration in the supplying arteries they tend to occur in patches, areas of atrophy being interspersed with areas wherein the capillaries appear to be compensatorily dilated. This patchy sclerosis may be quite evident ophthalmoscopically, especially in lightly pigmented individuals, when the thickening in the arterial walls may become visible; pathologically the corresponding area of the chorio-capillaris is found to be atrophied, producing an irregularity with many variations in caliber in the capillary network. All these changes are particularly evident near the posterior pole, and in the region immediately around the disc . . ."

The role which these vessel changes plays in the development of definite pathological entities, while certain, is in many specific instances intangible. Degenerating processes, as they develop, may be the result of disturbances in nutrition, and this apparently from vessel sclerosis.

Two clean-cut pathological conditions, primary, with such vessel changes can be mentioned as an illustration. The first is the so-called senile degeneration of the macula. This results from closure of the choroidal circulation with a secondary hyaline degeneration. The entire thickness of the choroid is affected, and colloid degeneration appears in one of the membrances of the choroid, i.e., Bruch's membrane. The pigment cells show proliferation with atrophy and with the deposition of extracellular pigment. The top layers of the retina become disorganized and atrophied because their nutritional circulation is destroyed; this continues until all retina elements, as cones, disappear and the residual picture is one of thickened choroid, thinned out atrophic retina, and their replacement by scar tissue, with only a few degenerated retinal cells remaining close to the internal limiting membrane.

The second classical picture of primary senile vessel disturbances is the so-called senile peripapillary halo, due to the closure of the choroidal vessels near and at the posterior pole of the eyeball, as these are grouped about the optic nerve papilla. The sequence of consequent pathological change is similar.

Examples of the indirect effect of these vessel changes are perhaps of greater pathological significance. Noninflammatory forms of chronic primary glaucoma must certainly be considered. The retinopathies of diabetes; of arteriosclerosis and of chronic nephritis; of central retinal vein and central retinal artery disturbances, as seen in thrombosis and embolism of these

vessels—these and many others are characteristic.

Another of the basic processes mentioned in considering Kornsweig's microscopic analyses are the various forms of degeneration—cystic, hyaline and proliferative. Some of the changes which occur as a result of degenerations are not particularly significant, even though they may be an accompaniment of senility, for their effect upon visual acuity will be of no importance. In some instances, however, the same process in a different portion of the retina will be, in terms of visual acuity, of tremendous significance.

Senile cystic degeneration of the ora is a common finding in the retina of old people. Under ordinary circumstances the importance of this is very slight when considering central visual acuity though its presence is rather likely one of the greatest factors in the development of retinal separation following a cataract operation in old people. It is true that there are other factors of importance in the development of this most distressing and serious condition but this is a constant finding. (The presence of senile cystic degeneration at the ora is probably of importance in the development of retinal separation even without a relationship to cataract surgery.) Of constant importance, in terms of this cystic senile degeneration, is this similar degenerative process whenever it occurs at the macula. Because of that, cystic degeneration is always serious from a visual acuity prognosis standpoint.

Again quoting Duke-Elder: "Like the periphery, the macula region is also prone to cystic degeneration, which shows the same pathological characteristics." In this, while its pathological identification is old, its recognition clinically, as a not uncommon occurrence, is comparatively recent. In this type of cystic degeneration, occurring as it does in this very thin portion of the retina, there is one frequent finding, the macular hole of senescence. This was first described by Kuhnt. The cyst at the macula apparently ruptures, and because the anatomical arrangement of the vessels in this region makes reabsorption of fluid difficult, disintegration of the degenerative tissues occurs with the development of this hole.

There are other cystic and degenerative changes, as described by Kuhnt and others which occur in the ciliary body. The simplest of these, of course, is the fibrosis and hyalinization of the ciliary muscle and the suspensory ligament of the lens. Historically this is a process connected with advancing years known for ages. It is a part of that process known as presbyopia. At various times in the past some physiologists and ophthalmologists have made an attempt to correlate presbyopia with a period of life expectancy and to compare its early onset with longevity. It is doubtful, however, whether anything conclusive or authoritive has ever been deduced from such rationalization and analysis.

Other changes in the ciliary body may also be associated with this condition; it is so common as to be considered normal aging, if such a process is normal. Proliferation of the pigment layer of the epithelium and the pars planum of the ciliary body, and the cystic-like separation of the nonpigmented from pigmented epithelium in this region by a thin layer of exudate, or transudate, are frequently seen.

Another condition to be considered, appearing in this region, and of a degenerative type, and which has already been referred to, is simple noninflammatory glaucoma. The age at which this manifests itself most commonly is most significant, i.e., after the fifth decade of life. It has, in addition, a marked familial relationship, and its common symbiosis with cataract identifies it as another manifestation of senescence.

Simple primary non-inflammatory glaucoma is by no means limited in incidence to the aged. It is, however, undeniably a disease of the later years of life. It is remarkable how common it is to find this present and undiagnosed as a compensated form of glaucoma in the aging individual. The patient is not only wholly symptom free, but not uncommonly is unaware of the cause for the slowly progressing loss of vision. Everyone has heard the statement made that "the vision is failing because of age." It is true, aging is the underlying cause, but

the exact reason for the failure in vision is the sclerosing process which is occurring in the anteriorly placed filtering channels connected with the Schlemm's Canal system and the accompanying blood channels.

There is another, rather tragic, side to this situation, and that is the fact that these patients frequently do not respond well to surgery. Actually, it seems as if many of them are held at maximum visual efficiency and their failing vision best conserved by intelligent medication.

While nuclear sclerosis will be discussed later, at this time it is relevant to consider the secondary glaucoma of a neglected cataract. This is seen not uncommonly in the aged. The condition is usually in one eye only for the patient usually develops senile cataracts in the two eyes to a dissimilar degree. One eye retains fairly good vision, while the other proceeds inexorably to lost vision from the cataract. A state of satisfactory one-eyed vision seems to do for these patients sufficiently, psychologically, and hence they fail to have the maturing senile cataract extracted. A low grade secondary glaucoma frequently develops, though with good compensation, so that the eye remains painless and the patient continues unaware of his steady progress toward blindness in these neglected cases. The central and peripheral impairment of vision by the developing cataract keeps the patient unaware of the accompanying permanent loss in his field of vision, an accompaniment of the glaucoma. It is quite unnecessary that this too frequent accompaniment of old age should be permitted to continue to blindness. The patient is not alone at fault for proper advice from a physician could have prevented it.

Frank arteriosclerosis with its consequent retinopathy should be discussed in some detail. Arteriosclerosis is, of itself, not a great factor in destroying visual acuity. The complications of arteriosclerosis, as the degenerations which develop through arteriosclerosis, are the conditions of significance. In view of the fact that these pathological states have an occasional appearance in young people, it is quote proper to presume that some other factor in addition, in the young, besides arteriosclerosis, is causative; either as an additional factor, or itself the cause of the vascular pathology. That factor is possibly toxic and either of an infectious or of a metabolic variety. Nevertheless, there is a certain dependence of retinal and choroidal degenerations, in the older patient, upon vascular conditions because of the constant finding of the two simultaneously. A patient of advanced years may have 6/6 vision and show, at the same time, marked sclerosis of his retinal arterioles. Should that patient, however, develop, for instance, circinate degeneration of his macula; hyaline degeneration at the posterior pole of the eye from choroidal sclerosis; choroidal or retinal hemorrhages, even if only of capillary type; thrombosis of the central retinal vein or a branch thrombosis of the central retinal vein; or closure of the central retinal artery from angio-spasm or any other factor which causes this; then, also, that patient has become visually incapacitated. This means, so frequently, a burden upon himself, his relatives and, too often, upon the state.

These are some of the basic conditions related to the advancing longevity of the race, as related to the peripheral circulation. It is not idle conjecture to wonder if these signs of degeneration are to increase proportionately to the increase in longevity.

The problems of geriatrics, as devoted to research and the clinical study of the diseases and processes of the aged, are enormously influenced by the cardio-vascular-renal mechanics in the aged, generally speaking—and in an elderly person, when discussing a single individual. This applies equally to any branch of medicine, as it does to the anatomy of any vital organ. Thewlis very recently wrote, "Hardening of the arteries is a tough assignment for an elderly person to face. The doctor who gives it might as well knock him over the head with a crowbar. The 75-year-old man goes away from a physician's office with the diagnosis of a "little arteriosclerosis" and a bottle of phenobarbital tablets—a diagnosis and a prescription which constitute the geriatric knowledge of some physicians with little or no interest in the aged person. The

family physician should take a genuine interest in geriatrics and not function merely as a "pill pusher" who dubs every old person arteriosclerotic just because he is sometimes dizzy or falls asleep in a stuffy room."

Arteriosclerosis as a diagnosis is commonly unwarranted. It is a well-known fact that many people with well-established arteriosclerotic changes in the retinal vessels (hence a logical presumption is that the same process is present in the cerebral vessels), have no mental signs or symptoms whatsoever of encephalopathy. It is equally common knowledge that elderly people with extensive mental changes may show relatively few cerebral changes of arteriosclerosis at autopsy. To quote another paragraph from Thelwis, "One might make a geriatric slogan: Don't make a diagnosis of arteriosclerosis just because the patient is old. The autopsy may prove you wrong. Also, the presence of arteriosclerosis in the peripheral vessels does not mean, ipso facto, that the coronary and cerebral arteries are involved."

These comments just made relative to arteriosclerosis, while of greatest significance in discussing general medicine, have an exactly similar relationship when applied to ophthalmic pathology. There is no possible way to disregard the tremendous effects which disturbances of the cardio-vascular-renal system cause in the aged. Findings at postmortem on twenty-five subjects, all over 90 years of age, have been described by Drs. Trevor H. Howell and A. P. Piggot of London, England, in "Morbid Anatomy in the Tenth Decade." They say, "The most common lesions included atheroma of the aorta, pulmonary edema, atrophic emphysema, left ventricular hypertrophy, some forms of myocardial degeneration and changes in the valves of the heart." Considering this, as well as the earlier comments, one must neither undervalue the first, nor disregard this latter; that is, arteriosclerosis without retinopathy and advancing years without retinopathy.

It is possible, in the future, that these advancing years will be preceded by a period of better cardio-vascular-renal health and integrity so that the incidence of such ocular degenerative processes will not increase in proportion to that increase in the life span of the human race. At the present time it does not seem that such an anatomic, nonpathologic compensation is effective.

A few years ago, an eminent professor of metabolic diseases was heard making the statement that "diabetics are developing more vascular disease" (the opinion was made relative to diabetic retinopathy) "because they are living longer from the use of insulin." This statement is fallacious, unsound and unfortunate. Diabetes is not a disease of senility, that is understood and granted. The statement, however, illustrates this expressed query as to the possible increase in the incidence of degenerative conditions based upon arteriosclerosis.

The next process to be considered is that of linticular sclerosis, so-called senile cataract. Diseases of the lens resulting in a disturbance of its transparency and hence the development of cataract, are due to so many different causes that one can only consider senile cataract as relevant to our presentation. As Duke-Elder said:

"A very large number of theories have been put forward to explain the etiology of cataract. Most of them suffer from the defect of generality and in the attempt to embrace all types of cataract in one category. There is no reason to suppose that there is only one cause, or one principal cause operative in all cases, and doubtless there are many factors capable of initiating the pathological changes. It may be said at once that in no case is the mechanism understood, but it is necessary to review the various viewpoints put forward. These theories may be divided into five classes:

"1. Biological. (a) An expression of senility. (b) Genetic theories.

"2. Immunological.

"3. Functional, due to excessive accommodation.

"4. Local disturbances (a) of nutrient supply; (b) of the chemistry of the lens.

"5. General metabolic disturbances. (a) General toxemia. (b) Conditions of deficiency. (c) Endocrine disturbances.

"In man cataract is primarily associated with senility, and there is no doubt that in

the senile cases this factor plays a preponderant role; in conditions of senile sclerosis of the lens it is possibly the sole factor. In this respect the lens merely shows the characteristics of all tisues which grow until maturity is reached and then descend into senescence. This evolution is seen strikingly in the epithelial tissues, among which senile cataract may be compared to the whitening of the hair, the brittleness of the nails and the wrinkling of the skin. The changes in the sclerosed lens correspond to those of aging tissues generally—a gradual dehydration with a loss of the waterbinding capacity, a diminished metabolism, an accumulation of waste material with the deposition of sterol and calcium deposits, a decrease in permeability, and a rearrangement of the mineral skeleton of the tissue. These changes, of course, are affected by other conditions—the results of the stresses and strains of life, the cumulative effect of low-grade toxins acting over a long time, endocrine failure, and the little understood but immensely important effects of constitution and heredity."

Many of the causes listed have a relationship to advancing years. Certainly there is an irrefutable heredity element in senile cataract suggesting the possible influence of some genetic background. Local disturbances related to the nutrient supply of the lens, in spite of its low metabolic demand, are quite within reason. Such altered situations, whether due to age, the effects of heat and light, or of toxic substances, could be related to a gradual sclerosis of the nuclear portion of the lens. In general this is to be considered as a normal physiological process as long as the nuclear tissue continues transparent. The adult nucleus progresses throughout life to an increasing compactness toward the center of the lens by the development of the younger cortex substances. Other changes, histological and chemical, occur, which need not be detailed at this time. Functionally, while visual acuity remains unimpaired, this increased "consistency of the nucleus" (as Duke-Elder describes it) results in diminished accommodative adaptability. So-called nuclear cataract is simply the continued advance of this so-called physiological process, this spreading toward the periphery of the lens until surgery is necessary because of progressive loss of visual acuity. The ophthalmological signs, symptoms and accompaniment of this ocular state are so well known by ophthalmologists that it is not necessary to detail them here.

It is permissible to comment here relative to the black color of some of these old nuclear cataracts because it calls our attention to a biochemical change seen only in senility. The origin of this color is still under controversy. Recent investigations seem to suggest that this black color of cataracta nigra is not true melanin but is a related pigment known as lipofuscin. This is probably from an interaction of cysteine and protamine, the first of these being derived from glutathione and the second from the disintegration of the nuclear proteins in the center fibers of the lens.

Other pathological senile changes in the lens occur in the cortex of the lens, and in the various zones of the lens as these are known to us. Hydration of the cortex occurs with the accumulation of fluid. Vacuoles appear, either under the capsule or in the interior of the lens, clear clefts are formed as radial fissures. Lamellar separation appears and granular debris develops in the subcapsular zones. The picture of senile lenticular degeneration is well known and easily diagnosed. Probably 65 per cent of all persons over the age of 50 and 90 per cent of all people over the age of 60 years show senile opacities. In the final analysis the word "senile cataract" should not be used in discussions with patients with such lenticular opacities until such opacities have advanced to a state where a lens extraction is probably necessary in the near future.

Mention has already been made of a fault too common in the handling of senile cataract of a dissimilar degree of involvement. Patients with unilateral cataracts, when neglected, under the best of circumstances lose convergence and end with the cataractous eye in divergence, making any later probable postoperative binocular single vision difficult and frequently impossible. Under the worst of circumstances these

cases go on to secondary glaucoma and to blindness. At the best, single binocular vision is frequently imperfect with binocular aphakics unless the surgery is done on each eye with a rather short interval between the two operations. The technic of contact lens fitting has been perfected to such a satisfactory degree that early uniocular surgery and the subsequent wearing of a single contact lens is common and good binocular single vision is achieved with but little difficulty.

As a logical third subdivision of this presentation is the general question of geriatrics; for that will certainly apply as well to ophthalmology. At a recent National Conference on Aging, gerontotherapeutics, a term invented by Benjamin to describe the treatment of the aging process, was an important subject. Gardner called attention to at least four elements in the problem of gerontotherapeutics which must be investigated. As he said (Gardner) the widening of the healthy middle span of life will decrease the period of senility as well as increase the average life span. The four elements in the matter of therapeutics are (1) an investigation of the vitamin field, not only for therapeutic treatment in geriatrics, but also as a preventive measure in gerontotherapeutics; (2) hormones and their effect upon the senescent period must be studied more effectively. As Gardner said, "Complete evaluation of hormones in the aging process must still be determined." The investigation and the identification of growth factors is the third element. Relative to this Gardner quotes the work of Carrel and his co-workers. He (Gardner) feels that this phase of the problem will take the greatest length of time to develop but that its solution offers the greatest returns. The fourth factor in the discussion being quoted (though listed as third in the original paper) is the breakdown of the cardiovascular system and the prevention or elimination of this type of breakdown. Some of this work is out of the experimental laboratory and has now reached the clinical stage.

In general, the rejuvenative, a preventive, and an eliminative treatment of senility are the problems which are facing medicine in the future. The first of these suggests a reversal of the functions of senile organs toward that efficiency seen at a younger age. The second consists of the prevention of the processes of aging and, if these have already developed, of their elimination by medical or surgical treatment. This has been discussed recently to a degree almost basic by V. Korenchevsky, who is head of the Gerontological Research Unit, Oxford, England. The conclusions as outlined by Korenchevsky will be quoted verbatim as the conclusion to this paper. They are the result of meditation, rationalization and evaluation of such factors as are necessary for animal experimentation in geriatric research; the recognition of the fact that the morphology, physiology, and biochemistry of a growing organism are substantially different from those of the adult and ever so much more different than those of an old individual, and that the cessation of growth processes is responsible for these differences in the adult. There are numerous diseases which complicate pathological aging, hence responsible for many features of abnormal senility. The third generality, in this—the elimination of these diseases—would be a gigantic step in gerontological research.

In addition to these primary situations, there are other secondary possibilities, perhaps even more significant, related to metabolic waste substances; the action of vitamins, as well as the significance of other nutritional substances; and even a discussion of habits and clothing and hours of sleep. All are factors which have been sufficiently and superficially studied.

Korenchevsky's conclusions at his presentation follow herewith, verbatim. To the author they seem to be the most significant and pertinent group of basic principles so far presented to us. As Edward J. Stieglitz said at a recent National Conference on Aging, "If it is sensible for the child to prepare to become an adult, it is equally so for the adult to prepare for his later years."

Conclusions

1. "At present, the harmless, and from a practical point of view, the most promising

lines of geriatric research are preventive and eliminative treatment of senility.

2. "The rejuvenative treatment of senility, on the contrary, might easily become dangerous in its practical applications, as the experiments on rats suggest. Its danger is not only in simultaneous production of pathological changes in various organs, but also in its tendency to change the nature of the species. Even if the latter is far from ideal, it is necessary to remember that all the features of the species were fixed after millions of years of biological development. Therefore, all attempts to change these features place a great responsibility on the gerontologists and necessitate the greatest caution.

3. "Before starting geriatric treatment of human beings, numerous morphological, physiological and biochemical geriatric experiments on animals, in properly equipped research centers, have to be performed in order to ascertain the favorable effects, and absence of any harmful action.

4. "A possibility of reversing some of the senile organs and functions in rats to the level observed at a younger age suggests that unexpectedly important results, which might change all our outlook on the problems of aging, could be obtained in research on old age."

BILATERAL CORTICAL NECROSIS OF THE KIDNEY

A. J. McQUEENEY, M.D.* and H. K. SPEED, JR., M.D.†
ALBUQUERQUE, NEW MEXICO

Bilateral cortical necrosis of the kidney, in spite of its rarity, has, in recent years, engaged the attention of urologists, internists and surgeons because, presenting clinically as a type of anuria, it poses extremely difficult diagnostic and therapeutic problems. The most recent review (Duff and More, 1941) of the subject shows only twenty-three reported cases not associated with pregnancy and only one with an associated peritonitis. Consequently, a case of this type is recorded herein, along with a brief review of the more recent literature.

Bilateral cortical necrosis of the kidney is an acute ischemic necrosis which symmetrically and diffusely involves the cortex of both kidneys, characteristically sparing the renal medullae and papillae. The etiology of this striking pathologic lesion is unknown and its exact pathogenesis remains a matter of conjecture.

Diagnosis

Of the total of seventy-one cases reviewed by Duff and More (1941), forty-eight were associated with pregnancy and the remaining twenty-three cases were associated with a wide variety of conditions including the following infections: scarlet fever, tonsillitis, grippe, hemolytic streptococcal infection following submucous resection of the nasal septum, diphtheria, lobar pneumonia, bacillary dysentery, therapeutic malarial infection, and pulmonary tuberculosis, all one case each.

An additional group of cases gave a history of exposure to an exogenous agent in concentrations which could be interpreted as toxic. Such agents included intravenous camphor (two cases), alcohol, local anesthetic, almond extract, cobra venom, and thyroid extract, all one case each. In three typical cases there was no associated disease or demonstrable related etiologic factor. Ash (1933) included one case which was associated with traumatic rupture of the liver in an automobile accident, with no demonstrable direct renal damage. Bilateral cortical necrosis of the kidneys has also been noted occurring in association with thrombocytopenic purpura, extreme dehydration, perforated gastric ulcer, obstetrical shock, and following severe burns.

From the foregoing it is evident that the history is that of the associated condition, usually pregnancy or infection, and would rarely be helpful in providing a diagnostic lead. More important is the clinical picture of oliguria progressing to anuria with nitro-

*Pathologist, Van Atta Laboratories.
†Recalled to active military service.

gen retention. These findings are almost invariably present in reported cases. In the sixty-two cases reviewed by Ash, the significant laboratory findings ranged as follows: NPN 100-300 mg. per cent; BUN 75-388 mg. per cent; Creatinine 6-12 mg. per cent. In spite of the azotemia, blood pressure is normal in the majority of cases, but the urine shows albumin as a constant finding with casts in most cases. The duration of anuria is variable, ranging from two to seven days, but appears to have little influence on the terminal pathologic picture.

Differential diagnosis is exceedingly difficult. Since most all cases present clinically as anuria of undetermined origin, it is important to exclude obstructive types of anuria by careful urologic examination. In cases of cortical necrosis associated with pregnancy, it is difficult or impossible to differentiate chronic nephritis unless there is a definite history of pre-existing renal disease. Renal infarction may likewise simulate the clinical picture of bilateral cortical necrosis although anuria is a less constant feature in renal infarction, which usually occurs as an embolic complication of known cardiovascular disease. The anuria and "lower nephron" nephrosis sometimes associated with severe transfusion reactions, crushing injury, etc., can usually be differentiated on the basis of history, associated findings and clinical course.

CASE REPORT

History: Mrs. J. L., a 77-year-old Spanish-American housewife, was admitted to the Southwestern Presbyterian Hospital on June 6, 1949, complaining of abdominal pain of three days' duration. She was in apparent good health until three days prior to entry when she developed left-sided abdominal pain of a severe cramping nature associated with marked vomiting and later slight distention. Physical examination revealed marked tenderness throughout the left side of the abdomen with slight rigidity. B.P., 110/80 to 92/58. Urine showed 2 plus albumin, 3-5 R.B.C., 10-15 W.B.C. and numerous hyalin casts. W.B.C. on admission, 19,000 with 72 per cent polys, later rising to 40,200 with 90 per cent polys.

She developed partial and then complete anuria on the second hospital day, but cystoscopy and ureteral catheterization revealed no evidence of nephrolithiasis or obstructive uropathy. The findings were interpreted as consistent with bilateral non-obstructive anuria.

The NPN rose to 157 mg. per cent and the patient ran an afebrile rapid downhill course with continuing anuria, azotemia, and coma, expiring on June 9, 1949, the third hospital day.

During her brief illness she received streptomycin, penicillin, and I.V. 5 per cent glucose in saline, but no blood transfusions, or vasopressor substances.

Pathology: At autopsy the abdominal cavity contained approximately 1,000 c.c. of dark yellow sero-fibrinous fluid with a localized appendiceal peritonitis due to perforation of the appendix which had been partially walled off in the lateral gutter. The area of localized peritonitis involved the cecum and lower third of the ascending colon. There was also evidence of diffuse pelvic peritonitis with a third area of localized peritonitis involving the upper pole of the spleen and the greater curvature of the stomach near the fundus.

The kidneys were similar in appearance, each weighing approximately 130 grams. On longitudinal sectioning, the cortex was of normal thickness and appeared as a pale grey-yellow necrotic band extending the entire length of the kidney. The renal surface was smooth, presenting

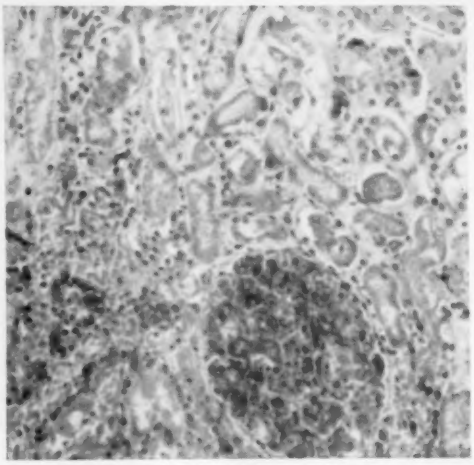

Fig. 1. Kidney, showing almost complete loss of structure in the diffusely necrotic cortex (H. & E. X100).

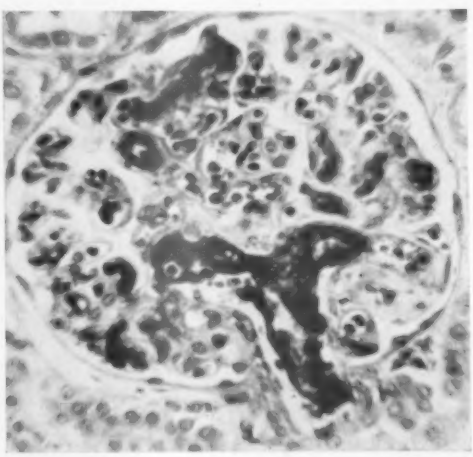

Fig. 2. Kidney, glomerulus showing occulsion of capillaries and afferent arteriole by fibrinoid thrombi (Masson X450).

a mottled appearance due to the presence of numerous small petechial subcapsular hemorrhages. The renal capsule stripped with ease, and the pelves and calices were not remarkable.

On microscopic examination, the renal cortex of both kidneys showed confluent foci of cortical necrosis which produced infarct-like areas marginated by a reactive zone of neutrophilic infiltration. (Fig. 1). The renal tubular epithelium and glomeruli were both involved, but in some areas there was a narrow sub-capsular zone where tubules appear well preserved. Many glomeruli showed fibrinoid necrosis and swelling of the glomerular capillaries with apparent occulsion of their lumina by thrombotic fibrinoid masses. Similar thrombi were present in afferent arterioles (Fig. 2). Smaller arterioles showed slight hyperplastic thickening and the larger vessels a slight to moderate degree of sub-intimal thickening, but no thrombotic lesions. No arterioleonecrosis was demonstrable. Coarse granular and large amorphous pigment masses were noted within the tubular epithelium and lumina.

The final anatomical diagnosis was:

1. Acute appendicitis with perforations and peritonitis.
2. Bilateral cortical necrosis of kidneys (clinically, uremia).

Pathology

The basic pathologic anatomy is well illustrated by the foregoing case and is similar to that of all reported cases. The diagnostic feature is an acute diffuse bilateral ischemic necrosis involving the renal cortex, but sparing the renal medullae and papillae. A thin (1-2 mm.) subcapsular zone of cortez is likewise often preserved.

Worthy of emphasis is the fact that the characteristic vascular changes are limited exclusively to the smaller vessels of the renal cortex; and generalized vascular disease is uncommon or absent. Even within the kidney itself, the larger arteries remain uninvolved.

In typical cases, no constant changes are noted in other organs, and the only variable in the pathologic picture is in the distribution of thrombotic and necrotizing changes in glomeruli, afferent arterioles and smaller cortical arteries. According to Duff and More, one-third of reported cases show necrotizing arteris of the smaller (intralobular) arteries and afferent arterioles. In the present case arterioles are virtually free of thrombi, while glomerular capillaries are plugged by hyaline or fibrinoid eosinophilic masses, occasionally even in non-necrotic zones.

Pathogenesis

While the exact pathogenesis of bilateral cortical necrosis of the kidneys remains a matter of speculation and conjecture, there are certain areas of agreement evident in reviewing the literature on the subject.

Most authors agree that the characteristic symmetrical bilateral lesion is produced by intense and prolonged vasospasm of the smaller arteries and arterioles of the renal cortex. The consequent ischemia results in first, cortical anoxia, then cortical necrosis, and finally, secondary necrotizing and thrombotic changes in the vessels themselves.

The trigger mechanism which initiates the vasospasm is unknown, but several attractive theories have been advanced. In pregnancy cases, unassociated with infection, the vasospasm may result from the direct action of vasopressor substances of undetermined origin upon hyperirritable cortical vessels. Such a view is supported by the experimental production of bilateral cortical necrosis by the injection of vasopressin (pitressin).

In those cases associated with infection, the vasospasm may be initiated by the action of circulating bacterial toxins on renal cortical arteries which are hyperirritable or have become previously sensitized by a generalized Shwartzman type of phenomenon. This mechanism is consistent with the work of Von Glahn who produced typical renal cortical necrosis by injection of hemolytic staphylococcus aureus toxin; similar results were noted by Black-Shaffer following the injection of meningococcic bacterial filtrates. Further support of this theory is given by the studies of Trueta (1947) who describes a vascular shunt mechanism in the kidney which diverts blood from the renal cortex to the medulla and can be initiated by various stimuli, including staphylococcic toxin.

Prognosis and Treatment

In the strict pathologic sense, bilateral cortical necrosis is invariably fatal for, as pointed out by Ash, the diffuse destruction of the renal cortex which characterizes the condition is tantamount to bilateral nephrectomy. In early cases, however, where the lesion is incompletely developed and has not progressed beyond the stage of cortical anoxia, it is conceivable that the changes

are reversible and that recovery is possible. Decapsulation of the kidney has been practiced with varying degrees of enthusiasm and unimpressive results for years. Yet Ash felt that decapsulation still might be worthy of trial in selected cases.

Although there is substantial agreement as to the vasomotor origin of the ischemia, the condition is so uncommon and clinical diagnosis so difficult that the effect of therapeutic nerve block remains relatively unexplored. If the nature of the renal lesion and the anuria were apparent early in the course of the disease, it is conceivable that paravertebral block or spinal anesthesia might restore cortical blood supply prior to the onset of ischemic necrosis.

Summary

A case of bilateral necrosis of the kidney associated with purulent peritonitis is reported and the pertinent literature is briefly reviewed with emphasis on the pathogenesis of this uncommon but interesting renal lesion.

THE EFFECT ON MORBIDITY OF ABDOMINAL SURGICAL WOUNDS MANAGED WITHOUT POSTOPERATIVE DRESSINGS*

REVIEW OF 200 CASES

OSCAR J. ROJO, M.D., and JOHN R. PRATT, M.D.
SHERIDAN, WYOMING

Until some years ago, the preparation of a patient for gynecological and abdominal surgery was a serious and complicated procedure. The abdomen and perineum were shaved, washed with soap and water, then swabbed with alcohol or ether, and covered with a sterile towel. This was done about twelve to eighteen hours prior to surgery. The patient then received enemas until the solution was returned clear. Several vaginal douches were given, usually with a strong antiseptic solution, in an attempt to eliminate bacteria as much as possible.

Postoperatively, gauze sponges, an abdominal pad, and several inches of adhesive tape from the xyphoid to the sympysis were supplied. If the patient was heavy, scultetus binder was added, constricting the abdomen and limiting respiratory movements. An associated vaginal plastic operation, which was not common, required a T binder holding several dressings over the perineum.

Upon returning to her room the patient was kept warm and placed in a Fowler's position. She was not allowed to move and sometimes was kept in bed for a week after surgery. As a rule a patient was kept in the hospital from two to three weeks following major surgery.

Nowadays we have simplified the pre- and postoperative care of these patients considerably without increasing the mortality or morbidity. This has been possible because of our present knowledge of chemotherapy and antibiotics and also because of research and the pioneering "point of view" manifested by those who first dared to use this unorthodox method of postoperative management of surgical wounds. At present we don't prepare the abdomen and perineum some hours before surgery. We do not try to dehydrate the patient by giving several enemas, or try to scald the vagina with strong antiseptic douches.

Postoperatively we do not place the patient in Fowler's position because it interferes with the venous flow and increases the danger of thrombophlebitis and phlebothrombosis. We do not keep the patient in bed for several days thereby increasing the danger of atelectasis and pneumonia, and the patient usually leaves the hospital about seven days following surgery.

Although, at the present time, the use of the scultetus binder is limited and the body is not wrapped with adhesive tape impairing chest expansion, most of the surgeons continue to use abdominal dressings.

Two years ago, Dr. William Mengert read, at the annual meeting of the South Atlantic Association of Obstetrics and Gynecology,

*Presented before the Sheridan County Medical Society, September 11, 1951.

a paper entitled "Simplified Gynecological Care." In this paper, Dr. Mengert emphasized the care of abdominal wounds. Since January, 1946, he has not used any abdominal dressings and the results have been excellent. His conclusions were:

1. The wound is allowed to seal itself with fibrin within a few minutes after closure.

2. The fibrin seal is a far more effective protection against bacterial invasion than gauze.

3. The moisture, otherwise accumulating underneath any dressing, evaporates and does not liquify the fibrin seal.

This treatment of wounds is not new. It was used in gynecology years ago by Berkely and Bonney in England, and it is used by most plastic surgeons.

At present, it is followed in some leading institutions all over the United States. Dr. Herbert E. Schmitz in Chicago has been managing his abdominal wounds in this manner since 1948. Nevertheless, to my knowledge, there has not been any contribution to the literature for the past two years.

It is the purpose of this paper to present a comparative study of 200 cases of gynecological and abdominal surgery performed in a small hospital where only one operating room is available for all surgical cases. From January 1, 1950, to May 1, 1951, 569 major abdominal operations were performed at the Memorial Hospital of Sheridan, County; 100 of these were performed by the authors and dressings were not used. Of the remaining 469 cases operated by the staff, 100 cases were taken at random for comparison. In this group dressings were used. The standard used for morbidity was that of the American College of Surgeons, e.g., temperature of 100.4 for two successive days excluding the first twenty-four hours following surgery. It seems to us that this standard should be reconsidered and morbidity classified as mild, moderate and severe. In many instances, there are patients with a temperature of 100.4 for two successive days and no reason can be found to explain it. In this series every case was carefully evaluated.

The cases in this series did not require the use of antiseptics during the postoperative stay in the hospital, nor were any special measures taken as regards to patients' gowns and bed clothing. The gowns and sheets used on these patients were freshly laundered but they were not subjected to sterilization or other procedure other than the laundry procedure standard for all cases in the hospital. No special measures were taken to insure the fibrin seal of the wound as it is believed that this sealing occurs within a very few seconds following the skin closure.

TABLE 1

	Author's Group	Comparative's Group
Hysterectomies, total	18	5
Sub-total	4	15
Laparotomies	14	12
Cesarean sections	3	4
Salpingo-oophorectomies	7	8
Uterine suspension	1	1
Appendectomies	38	30
Cholecystectomies	6	10
Herniorrhaphies	6	12
Gastrectomies	2	2
Pre-sacro neurectomy	1	....
	100	100

TABLE 2
Morbidity

	Author's Group	Comparative's Group
G. U. infections	4	3
U. R. infections	3	4
Atelectasis	1	2
Pelvic peritonitis	1	1
Phlebitis	0	1
Blood transfusion	0	1
Dehiscence of wound	1	2
Infection of wound	1	7
Unknown	2	6
	13%	28%

Explanation

Our one death was due to cardiac decompensation in a 75-year-old man with a strangulated hernia. The dehiscence of the wound occurred six days postoperatively. This case had had an appendectomy and her postoperative course was complicated

by a pneumonia and subcutaneous hematoma of the incision. The infected wound followed a total abdominal hysterectomy in an obese patient with a myomatous uterus.

In the comparative group the death was the result of a pulmonary embolism following a herniorrhaphy. The two dehiscence cases were: (1) seven days after a laparotomy due to a subcutaneous hematoma; (2) in a case of a total abdominal hysterectomy complicated with internal hemorrhage and bowel obstruction. The seven cases of infected wounds followed these operations:

Hysterectomies	3 cases
Cholecystectomies, one of which had empyema of the gallbladder	2 cases
Appendectomy, ruptured appendix	1 case
Cesarean section	1 case

These figures are uncorrected, nevertheless they are very high indeed. This is probably due to the fact that we are dealing with a small series of unselected cases. Also, we have to consider that in the comparative group, these cases were operated upon and managed by twelve different surgeons. It is our belief that individual technic plays a very important role.

In our series the average period of hospitalization per patient was 7.91 days; in the comparative group, 9.38 days.

Conclusion

1. It is our belief that wounds heal better when dressings are not used.

2. Mortality or morbidity are not increased by the absence of dressings.

3. No special treatment of gowns or bed clothing is required in connection with the postoperative management of operative wounds without the use of dressings.

4. It is not necessary to use antiseptics in connection with the management of these "undressed" wounds.

It is becoming clear that pulmonary tuberculosis is more common in the middle-aged and elderly than was formerly believed; and the diagnosis should be considered in all cases with persistent chest symptoms.—M. B. Paul, M.D., The Lancet (London), August 11, 1951.

PROGRAM—ROCKY MOUNTAIN RADIOLOGICAL SOCIETY

The Fourteenth Annual Mid-Summer Conference of the Rocky Mountain Radiological Society will be held in Denver, Colorado, at the Shirley-Savoy Hotel on August 7, 8, 9, 1952. Guests are:

W. C. Banks, D.V.M., College Station, Texas—1. "Clinical Cases Occurring in Veterinary Radiology." 2. "Some Diseases of Dogs That Also Occur in Man."

Philip J. Hodes, M.D., Philadelphia, Pennsylvania—1. "The Roentgen Manifestations of Pancreatic and Periampullary Disease." 2. "The Roentgen Manifestations of Cerebellopontine Angle Tumors."

Harold O. Peterson, M.D., St. Paul, Minnesota—1. "The Roentgen Diagnosis of Benign Gastric Ulcer." 2. "Unusual Neurologic Conditions With Diagnostic Roentgen Findings."

George H. Ramsey, M.D., Rochester, New York—1. "Cinefluorographic Analysis of Some Movements of the Cervical Spine." 2. "Cinefluorographic Analysis of the Causes of Dysphagia."

A. Justin Williams, M.D., San Francisco, California—"Roentgen Diagnosis of Intra-Abdominal Hernia."

A symposium on diseases of animals transmissible to man will be presented from the standpoint of veterinary medicine as well as from the bacteriological, pathological and clinical viewpoints. Members and guests:

Richard B. Bridenbaugh, M.D., Billings, Montana—"Gallstone Ileus."

H. H. Dunham, M.D., Kansas City, Kansas—"Lymphosarcoma; A Review of One Hundred Cases."

William M. Kitchen, M.D., Kansas City, Missouri—"Examination of the Bleeding Colon."

Morris H. Levine, M.D., Denver, Colorado—"Beta Radiation of the Eye."

Gerald S. Maresh, M.D., Denver, Colorado—Roentgen Therapy in Lymphoid Hyperlasis of the Nasopharynx."

H. Marks, M.D., New York City, New York—"Palliative X-Ray Therapy With the Use of a Grid in Advanced Carcinoma."

J. R. Maxfield, Jr., M.D., Dallas, Texas—"Radioactive Iodine, I 131, as an Indicator of Thyroid Function and for the Therapy of Certain Thyroid Diseases."

J. Marshall Neely, M.D., Lincoln, Nebraska—"An Evaluation of Sella Tursica Changes, the Result of Introncranial Pathology."

Henry H. Plenk, M.D., Salt Lake City, Utah—"Aneurysmal Dilatation of the Great Vessels: The Use of Angiocardiography and Cardiac Catheterization in the Differential Diagnosis."

Marcus J. Smith, M.D., Santa Fe, New Mexico—"Roentgenographic Aspects of Complete and Incomplete Pulmonary Infection."

E. Dale Trout, Ph.D., Milwaukee, Wisconsin—"The Use of Filters to Control Patient Dose in Diagnostic Radiography."

C. Edgar Virden, M.D., Kansas City, Missouri—"Testicular Neoplasma."

Angus K. Wilson, M.D., Salt Lake City, Utah—"Investigations of Silicosis in Utah."

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bochgaard, Nielsen, Bang, Groeland, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[5]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31	[9]		11	4		11	88
Broders	60	60	58		1	1	35	19	6				10	1	49[9]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	60	76				35	27	10		4	10	26		10	38
Ogborn	42		39	2		1	42[3]									42
Sheikun	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1442	968	1380	17	8	38	1142	132	131	12	26	34	552	62	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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Organization

NEW MEXICO Medical Society

New Mexico Concludes Successful Meeting

The Seventieth Annual Meeting of the New Mexico Medical Society, held May 7 to 10 in Carlsbad, was a notable one with an exceptional attendance for a session held away from the state's population center, an outstanding program, and unusual entertainment.

COY S. STONE, M.D.

During the meeting, Dr. Coy S. Stone of Hobbs was installed as President, taking over the gavel relinquished by Outgoing President Leland Evans of Las Cruces. Dr. Albert S. Lathrop of Santa Fe was chosen President-elect and will assume the presidency next spring when the Seventy-first Annual Meeting will be held in Albuquerque.

Dr. Stone, whose Presidential Address appears elsewhere in this issue of the Journal, gave promise of a strong leadership for the coming year. For those who do not know him personally, a few facts about his career should be set down. He was born February 12, 1903, in Goree, Texas, and was graduated from Baylor University Medical School in Dallas in 1929. He served his internship at the Methodist Hospital in Dallas.

Dr. Stone began private practice in Hobbs, New Mexico, in 1931. Except for time spent in postgraduate work in surgery at the University of Pennsylvania Postgraduate School and four years' service in the Army Medical Corps during World War II, he has done private practice in Hobbs ever since. He is a Past President of the Lea County Medical Society, and has been active in county and state medical organizations for many years. He is a Fellow of the American College of Surgeons. Dr. and Mrs. Stone have a son and daughter, Bill, aged 17, and Sandra, 10.

MONTANA Medical Association

MONTANA MEDICAL ASSOCIATION

Proceedings of the

FIFTH INTERIM SESSION OF THE HOUSE OF DELEGATES

February 29, 1952

The Fifth Interim Session of the House of Delegates of the Montana Medical Association was called to order by F. L. McPhail, M.D., Great Falls, President, at 9:30 a.m. at the Placer Hotel, Helena.

Following the roll call of the delegates, the Secretary, Everett H. Lindstrom, M.D., Helena, announced that all delegates seated had presented proper credentials and that a quorum was present.

It was moved by Thomas W. Saam, M.D., Butte, that R. F. Peterson, M.D., Butte, be seated as a delegate from Silver Bow County Medical Society. This motion was seconded and carried. William E. Sullens, M.D., Great Falls, moved that Charles F. Little, M.D., Great Falls, be seated as a delegate from the Cascade County Medical Society. This motion was seconded and carried. Clyde H. Fredrickson, M.D., Missoula, moved that Leonard W. Brewer, M.D., Missoula, and Park W. Willis, M.D., Hamilton, be seated as delegates from Western Montana Medical Society. This motion was seconded and carried. William F. Cashmore, M.D., Helena, moved that Amos R. Little, M.D., Helena, be seated as a delegate from the Lewis and Clark County Medical Association. This motion was seconded and carried.

It was moved by Dr. Fredrickson that the reading of the minutes of the 73rd Annual Meeting of the House of Delegates, held in Great Falls, September 13-16, 1951, be dispensed with inasmuch as they have been published in the Rocky Mountain Medical Journal. This motion was regularly seconded and carried. It was then moved by Dr. Fredrickson and seconded that the minutes of the 73rd Annual Meeting be approved as published in the January, 1952, issue of the Rocky Mountain Medical Journal. Motion carried.

Report of AMA Delegate

Dr. Peterson, the delegate of this Association to the House of Delegates of the American Medical Association, reported upon the various actions of that body at its December meeting in Los Angeles. (The proceedings of this meeting were published in full in the December 22, 1951, issue of the Journal of the A.M.A.) There being no objection, the report of the delegate was ordered placed on file.

The following report of the Secretary-Treasurer was read by Dr. Everett H. Lindstrom:

Report of Secretary-Treasurer

The following is a consolidated statement of the income and expenses of operation during the calendar year 1951:

From among all antibiotics, Orthopedic Surgeons often choose

New aureomycin minimal dosage for adults—four 250 mg. capsules daily, with milk.

AUREOMYCIN

Hydrochloride Crystalline

because

Aureomycin, following oral administration, diffuses rapidly into the skeletal and structural tissues of the body.

Aureomycin exhibits little tendency to favor the development of resistant bacterial strains.

Aureomycin in daily repeated small dosage gives satisfactory serum levels, and may be continued over a long period.

Aureomycin has been reported to be clinically effective against susceptible organisms in the following conditions frequently seen by the orthopedic surgeon:
Suppurative Arthritis • Osteomyelitis
Infected Compound Fractures • Osteitis
Brucella Arthritis • Periostitis

Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

Capsules: 50 mg.—Bottles of 25 and 100; 250 mg.—Bottles of 16 and 100. *Ophthalmic:* Vials of 25 mg. with dropper; solution prepared by adding 5 cc. of distilled water.

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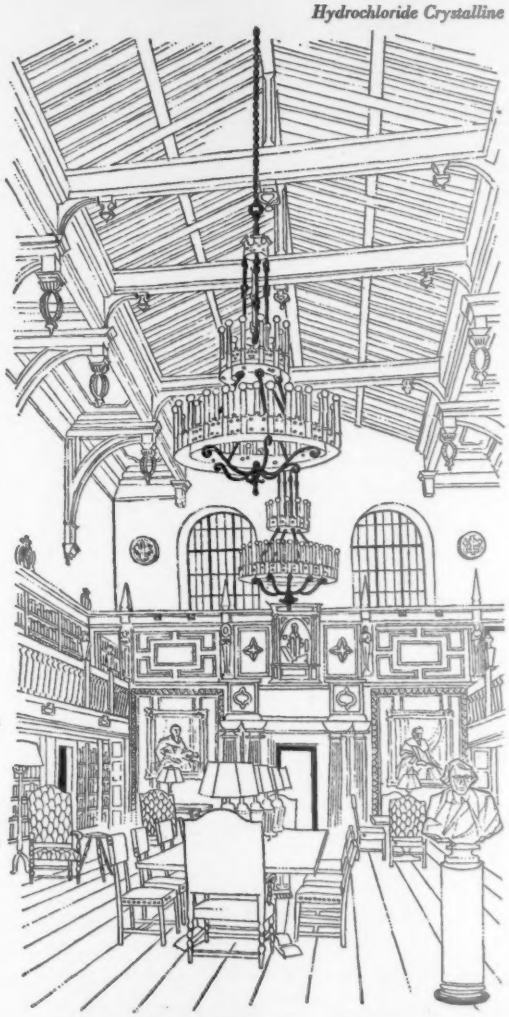

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INCOME		
1951 Membership dues	$21,600.00	
1949-50 Membership dues	175.00	
Sale of exhibit space	1,440.00	
Miscellaneous income and interest	245.47	
Total		$23,460.47

DISBURSEMENTS		
Office equipment	$ 595.70	
Maintenance and operation of central office	12,599.95*	
Meeting expenses (Annual and Interim)	1,928.91	
Legal and accounting expenses	632.63	
Officers and Executive Secretary travel expenses	2,741.06	
Committee expenses	244.33	
Member subscriptions, Rocky Mountain Medical Journal	1,082.50	
Membership dues, Public Health League of Montana	1,299.00	
Contributions and dues to related organizations	479.00	
Miscellaneous expenses	352.44	
Total		$21,955.52

The budget, as you know, is worked up by the Executive Secretary and then submitted to the Executive Committee for changes and final approval.

Our office has made an especial effort during the past year to increase our membership. It is apparent that to be really effective our Association should include nearly all the physicians practicing within our State. Letters were written to the secretaries of all the component societies urging that all non-member physicians in the district be invited to join the local society. A short time after this letter was mailed your Secretary wrote a personal letter of invitation to each of the non-members explaining the benefits to be derived from belonging to our Association. At this date, fifteen Montana physicians who were not members last year have remitted state and American Medical Association dues through their component societies.

To date, 321 members have remitted dues to this Association for 1952. You may recall that 418 members had paid their dues before the Annual Meeting in 1951 so that we have a considerable number who have not as yet remitted their dues.

Your Secretary and Executive Secretary both attended the Public Relations Conference of the American Medical Association, which was held prior to the mid-winter meeting of the American Medical Association in Los Angeles. It has become increasingly apparent that a sustained and continuous program must be carried out to develop friendly relations with the public. Our national and local associations must sell the cause of medical practice to the general public in much the same way as we sell ourselves to the patient when we give him treatment. A seemingly well-planned attempt seems to be under way by politicians and commentators and their press to make it appear that the medical organizations do not represent the rank and file of physicians. For that reason it is imperative that we have unity within our ranks. While we may have many divergent opinions on the conduct of medical practice and functions, we must support the majority decisions as made by our membership. We must work within our Association to improve and develop what we have long labored to achieve. Again may I remind you, as I have done previously in the Bulletin, that most complaints against physicians are against their fees and not against their method of treatment. Let us make the public understand that good medicine costs money, but that physicians do not attempt to charge all the traffic may bear. Our Blue Shield plan has become popular because it makes it possible for the patient to budget his medical expenses monthly at a fixed price for the services covered. We would do well to boost this plan at every opportunity and to do everything to improve it both for the patient and the member physician, as it is a corner stone in public relations at the present time. Let us not be misled by those who attack it from without our organization. You may be sure that those critics are doing so to gain something for themselves and not in the interests of the medical profession.

There being no objection, this report was ordered placed on file.

The following report of the Executive Committee was read by Secretary Lindstrom:

Report of the Executive Committee

Since the last Annual Meeting of the Montana Medical Association in Great Falls during September the Executive Committee has held three meetings to discuss and transact certain business of the Association which appeared to require immediate attention. The following report is a resume of the committee's actions:

1952 Budget: The Executive Committee has carefully reviewed and approved a budget prepared by the Secretary-Treasurer to govern the operation of the Association during the year 1952. The income of the Association during the current year has been conservatively estimated at $23,025.00. Anticipated expenditures have been estimated at $24,050.60. While the anticipated income and the expenses for 1952 indicate that there will be a deficit of just over $1,000.00, it is likely that our income and expenses for the year will about balance. Several items of expenses, which may not actually be incurred, have been authorized in the budget by the Executive Committee. It was deemed advisable, however, to include these possible emergency expense items in the event their expenditure became necessary.

1952 Annual Meeting: Upon the recommendation of the members of the Western Montana Medical Society, the Executive Committee voted to hold the Annual Session of the Association in Missoula, September 18-21, 1952. It is important that all citizens be informed of all issues concerning health in every election year. A concerted effort should be made by all groups to encourage all individuals to exercise their right to vote. The committee, therefore, has approved certain tentative plans of President McPhail to secure a nationally known individual to speak at the Annual Session.

Uniform Insurance Reporting Forms: At the last Annual Session in Great Falls, the House of Delegates voted to adopt a uniform insurance form to furnish essential information to the commercial underwriter on health and accident cases. This action of the House, however, did not include any instructions or provisions about furnishing the form to the members, and the Executive Committee, therefore, authorized the Executive Office to print and distribute the form to all Montana physicians on a cost basis. These forms are now being supplied by the Executive Office at $1.25 per hundred, or $1.00 per hundred in lots of five hundred or more. For the information of the House of Delegates the membership of the Association has enthusiastically approved the use of this form and nearly every member of the Association has ordered a supply. Since the form was made available in November of 1951, nearly 40,000 copies have been distributed.

Health Planning Committee: The Executive Committee has authorized a contribution of $100.00 to the Montana Health Planning Committee to help that organization finance its activities and defray administrative and travel expenses incurred by its chairman.

Committee Appointments: During the last few months the following members have been appointed by President McPhail, with the approval of your Executive Committee, to represent this Association on the group indicated:

M. A. Shillington, M.D., National Doctors' Committee for Improved Federal Medical Services.

E. P. Higgins, M.D., and W. S. Wilder, M.D., Advisory Committee on Narcotic and Alcohol Education.

M. A. Shillington, M.D., American Medical Education Foundation.

James M. Flinn, M.D., Montana State Committee on Practical Nursing.

Public Health Information: Through the courtesy of the State Board of Health, your Executive Committee has recently procured a supply of reports of the Presidential Address of William P. Shepard, M.D., to the American Public Health Association and has authorized the distribution of these reprints to Montana physicians. Because this address very clearly defines and explains the duties and responsibilities of Public Health officers and Public Health Departments, all physicians, we believe, will be interested in it and careful reading is suggested.

Postgraduate Courses: Your Committee has recently received an inquiry from the Head of the Department of Postgraduate Studies of the University of Utah Medical School, John F. Waldo, M.D., about the sponsorship of courses in Montana. For the information of the delegates the Program Committee of this Association will be asked to discuss with Dr. Waldo and his staff a program of postgraduate medical training and to submit further details and recommendations to the Committee and the House at the September meeting. The Program Committee will also be asked to correlate all programs of postgraduate study in Montana so that a well-planned series of courses may be presented to the membership at regular intervals.

Subscriptions to "Today's Health": Your Executive Committee has been advised that the Public Relations Committee of this Association will recommend in its report, which will be presented later

*Includes rent, salaries, printing, stationery, telephone, telegraph, etc.

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* *Postgrad. Med. 9:106, 1951.*

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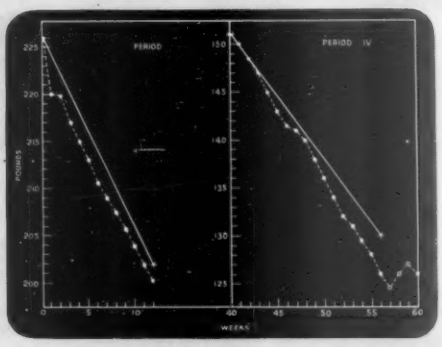

CHART OF WEIGHT LOSS
BROKEN LINE—OBSERVED LOSS • SOLID LINE—PREDICTED LOSS

in this meeting, that the Association purchase a number of subscriptions to "Today's Health," published by the American Medical Association, to present to certain elected governmental officials. The Executive Committee has approved the expenditure of the necessary funds, $19.50, for this purpose.

Dates for 1953 Annual Meeting: Because the number of conventions now being planned in the larger Montana cities and in view of the necessity of determining meeting dates at least two or three years in advance to insure the sale of a maximum number of exhibit spaces, your Executive Committee has voted to recommend that our 1953 Annual Meeting be held September 17-20 (Thursday, Friday, Saturday and Sunday). Under the plan of rotation of our meetings between the five Montana cities, this 1953 meeting will be held in Billings. The Billings Commercial Club and Billings hotels have reported that these dates are open and we have been informed that the dates will not conflict with meetings of other surrounding state medical associations.

Recommendation on Honorary Membership: The Executive Committee recognizes the very valuable and important contributions to medical science by Mr. Norman J. Holter of Helena and recommends to the Resolutions Committee that a resolution be presented to this House of Delegates to elect Mr. Holter to honorary membership in the Montana Medical Association.

The Coming National Elections: Your Executive Committee again wishes to impress members of the House of Delegates with the importance of the coming national elections. The Montana Medical Association and its component societies, as mentioned previously, cannot legally engage in a political campaign. Neither this Association nor its component societies can endorse a candidate for political office, contribute any funds for any candidate for federal office, nor sponsor any form of advertising material for a candidate. This Association and each of its component societies, however, not only have the right but the obligation to participate actively in registration drives and "Get Out the Vote" campaigns. The purpose of such campaigns must be to encourage citizens to exercise their right to vote, rather than to support any given candidate. Your committee feels it advisable to caution members of the medical profession about these legal limitations on their political activities and especially to advise officers of the component societies of this Association to participate in any political campaign as private citizens and NOT as officers of a medical society.

It is, your committee feels, most imperative that physicians as individual citizens, not under the auspices of their medical society, participate most actively in campaigns to encourage citizens to vote and in the campaigns of those political candidates who actively oppose any and all forms of socialism. Every physician must accept these responsibilities as a citizen.

There being no objection, this report was ordered placed on file by President McPhail.

It was moved by M. A. Shillington, M.D., Glendive, that the House of Delegates approve the recommendation of the Executive Committee that the 1953 Annual Meeting of this Association be held in Billings, September 17-20. This motion was regularly seconded and carried.

President McPhail at this time delivered an address on the affairs of the Association and the medical profession to the House of Delegates. (A copy of the address is on file in the executive office of the Association.)

The Chair recognized George A. Sexton, M.D., Great Falls, Chairman of the Resolutions Committee, who requested permission to present the following resolution to the House for action at this time:

> Resolved, That Norman J. Holter be elected to honorary membership in the Montana Medical Association for his distinguished services and attainments in the field of medical research.

It was moved by John E. Low, M.D., Sidney, that this resolution be adopted and Mr. Holter elected to honorary membership. This motion was seconded and carried unanimously.

The following report of the Economic Committee was presented by D. Ernest Hodges, M.D., Billings, Chairman:

Report of Economic Committee

This Committee has conducted its assigned duties, chiefly through correspondence and by telephone between members, the submission of a questionnaire to all Association members and the study of relevant material submitted or requested. We have studied three problems: (1) a group health and accident plan for Association members; (2) the question of a state-wide fee schedule; and (3) the relationships and opinions of Association members toward Montana Physicians' Service.

We have met to analyze our material and to agree upon this report in which we submit our findings and joint opinions for the consideration of the House of Delegates.

Group Health and Accident Plan: At our request and through our Executive Secretary, six or eight group health and accident plans have been submitted. There is nothing unusual about any of them; none furnish as liberal coverage for the fee charged as we believe can be obtained for a group of this character. We believe that our interests would be better served if we attempted to obtain a suitable plan through an insurance broker. This brokerage firm would be our expert, representing us. The Preston Agency of Great Falls has applied for this position and we believe that we should make an agreement with it, or with some other agency with equal facilities, to attempt to obtain this type of insurance for us. Our reasons for this recommendation are as follows:

a. The agent will represent us in all dealings with insurance companies and thus we shall avoid many pitfalls.

b. A tailor-made plan can be obtained more suitable to our needs.

c. Once the plan is selected an agency with a state-wide organization can promote its sale and service the plan so that we shall have a better chance to obtain the necessary percentage of participation. After this is obtained, the servicing of the policies will be most important.

This Committee feels that our Executive Committee should be empowered to make a brokerage agreement with a competent agency with a reasonable time limit of approximately six months. If, during this time the agency selected should present a better plan than we can otherwise obtain, then our Executive Committee should be empowered to act for the Association in accepting such a plan. There will be no cost to the Association or its members as the agency acting as broker will be compensated by the ordinary commissions of the insurance company.

Recapitulation of questionnaire in regard to Montana Physicians' Service:

Total questionnaires mailed to Montana physicians	528
Total questionnaires returned to committee	236

Analysis of Replies

Question 1: How do your usual charges for services to patients in the $3,000 to $5,000 income bracket, who are not members of M.P.S., compare with present M.P.S. fees?

Responses: Higher: 99; Lower: 3; Same: 121.

(The approximate percentage of those physicians charging a higher fee varied from 10 per cent to 100 per cent.)

Question 2: Do you customarily charge an additional fee to M.P.S. members who have an income in excess of $5,000 annually, or a net worth in excess of $20,000?

Responses: Yes: 59; No: 147.

(Many said they should, but the difficulty of getting data on patients' finances prevented doing so.)

Question 3: Do you believe it advisable for the Montana Medical Association to have a minimum fee schedule?

Responses: Yes: 178; No: 43.

(Many suggested an average fee schedule as better.)

Question 4: Do you favor tying-in the M.P.S. fee schedule and a proposed state association minimum fee schedule with some index such as "The Cost of Living Index" or "Commodity Price Index" of the United States Department of Labor?

Responses: Yes: 104; No: 95.

Question 5: What favorable or adverse criticisms do you have about any phase of the operations of M.P.S.?

Responses: Favorable comments: 28; No comments: 114; Mildly adverse comments: 55; Seriously adverse comments: 39.

The Question of a State-Wide Fee Schedule: Most of our members believe that a fee schedule is desirable. It appears to the Committee that an Average Fee Schedule is preferable to a minimum one.

It has occurred to the Committee that an Average Schedule should have some relationship to the M.P.S. schedule as it will probably play a part in

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*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:713 (June) 1947.

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our economics for some time. Study of the Nebraska plan shows that the unit type of schedule also has advantages in flexibility. In that state it was originated primarily for governmental agencies, but now has had wider application. The essence of the plan is as follows:

Every medical or surgical service is assigned a certain number of units; hence every service has a relative value to every other service. Once this relationship is determined, fees for services to particular groups can be quickly calculated by multiplying by the assigned value of the unit for that group. I will cite an example—suppose we say that our Average Fee unit is 10 cents and that M.P.S. unit is 6 cents and the agreed unit for a certain group is 8 cents. If the M.P.S. fee was $200.00 for a gall bladder, the average fee would be $333.00. The group fee would be $267.00. In the same manner we could decide on fee unit values for welfare cases, workman's compensation cases, etc., simply by using the same schedule of units and assigning the value per unit for each one.

It is the opinion of the Committee that the relationship of the M.P.S. fee to the average fee should be in the ratio of 6 to 10. We know that the relationships of the various M.P.S. fees are not all fair, but during the six months we could revise them as equitably as possible; then we would have our standardized schedule with which to work. Once our standardized unit schedule is compiled, it may be revised to meet changing conditions simply by changing the value of the unit whenever indicated.

Complaints About Blue Shield:

1. Long stationary fees in an increasingly inflated economy.

2. No recognition of competence obtained by years of postgraduate training to become a specialist. Impairment of incentive to do good work.

3. Destruction of patient-doctor relationship existing under a strictly private enterprise system of fee for service rendered in accordance with ability to pay.

4. Dangerous training in socialistic attitudes and habits—payments are deducted from wages or paid by employers; complete medical care is promised. Full explanation is not made that Blue Shield is a non-profit pre-payment plan where value in services is rendered only for money paid, except where it is subsidized by the physician.

There were many other complaints, but many were personal and not matters of principle. The ones just read are, however, in the opinion of the Committee, and more serious ones deserving study and effort at correction.

Beneficiary Members should not be led to believe that they are getting something for nothing. They should be told frankly that they are paying for what they get but, that due to its non-profit structure, they have received and will receive more for their money than any insurance company can afford to give them. They should be told that it was only possible to start the plan because the physicians were willing to donate part of their services in order to build it on a secure foundation with adequate reserves. They should be told that it can and will stand on its own feet now—the physicians should subsidize it no longer. They should now resume their right and duty to discuss the fees and services with their physician to reach a mutual agreement with their Blue Shield plan to give them major assistance.

Now, to make the doctor an even partner and participant in such a discussion of services and fees an indemnity plan will be necessary. It is realized, however, that a change to a straight indemnity plan presents some difficulties. The Committee feels that if an indemnity plan cannot be attained, an approximate approach to it may be obtained by reducing the mandatory acceptance of full payment to a lower income level, such as $2,000 for a single person or $3,000 for a family. Most of the people now obtaining so-called "paid in full" coverage will continue to do so, but the burden will be placed upon them to justify it to their doctors. This plan may care for the vexing problems of specialists' care and attendance by two physicians. The plan may, then, justify much more enthusiastic support from all physicians.

There being no objections, President McPhail ordered this report placed on file. The recommendations of the Economic Committee were then considered separately. It was moved by Dr. Shillington that, in accordance with the recommendation of the Economic Committee, the Executive Committee of this Association be empowered to execute a brokerage agreement with a competent insurance agency for a period of six months and that if such agency, during this time, presented an acceptable group health and accident insurance plan, the Executive Committee be empowered to act for the Association and accept the plan. This motion was seconded and carried.

It was then moved by Dr. Hodges and seconded that a special committee prepare an average fee schedule in which all phases of medicine and surgery are properly relative to each other and are as equitable as possible. During the discussion of this motion it was suggested that the Association might be unwise to adopt any fee schedule at the present time and that such action might better be deferred until the M.P.S. fee schedule has been carefully reviewed. It was then moved by Dr. Shillington and seconded that this motion be tabled pending further study. This motion, when put to a vote, was lost. Further discussion of the original motion indicated that the membership of the Association as a whole seemed to be in favor of the adoption of a fee schedule and that such a schedule be thoroughly representative of all phases of medicine and surgery. It was also pointed out that any schedule prepared by a committee of this Association must, of necessity, be presented to the House of Delegates for final approval before it became effective and that if deemed advisable at that time, the House could revise the proposal. Dr. Brewer then moved that the original motion be amended to state that the special committee shall be composed of a representative appointed by the appropriate officers of each medical specialty society and of three representatives selected from those physicians in general practice. This amendment was seconded and carried. Following further discussion of the original motion it was moved by Dr. Shillington and seconded that the original motion be amended to state that the special committee shall prepare the fee schedule under the direction of the Executive Committee of this Association and that the proposed fee schedule be submitted to the House of Delegates at its next Annual Meeting for consideration. This amendment, after discussion, was voted upon and carried.

President McPhail, for the information of the delegates, stated that the motion as amended would now read as follows:

> That a special committee composed of a representative appointed by the appropriate officer of each medical specialty society and of three representatives selected from those physicians in general practice prepare, under the direction of the Executive Committee of this Association, an average fee schedule in which all phases of medicine and surgery are properly relative to each other and are as equitable as possible and that this proposed fee schedule be submitted to the House of Delegates at its next Annual Meeting for final consideration.

This motion was then voted upon and carried.

Dr. Hodges moved that the recommendation of the Economic Committee that, upon approval of the fee schedule by the House of Delegates at its next Annual Meeting, the fee schedule shall be referred to the Board of Trustees of M.P.S. for study along with the recommendation that the M.P.S. fee schedule, for the present, shall be approximately 60 per cent of the average fee schedule of this Association. This motion was seconded. During the discussion of this motion some of the delegates questioned the advisability of including a definite ratio between the average fee schedule of this Association and the M.P.S. fee schedule. It was pointed out, however, that this ratio could be revised at any time by action of the House of

Delegates. This motion, when voted upon, was carried.

The following report of the Committee on Necrology and History of Medicine was read by the Chairman, Dr. Brewer:

Report on Necrology and History

Your Committee on Necrology and History of Medicine wishes to report that, at the present time, the manuscript of the History of Medicine in Montana is being copied so that it may be divided among the members of the Committee for further editing. As yet no steps have been taken to secure over-all editorial supervision.

The Association, since its last regular meeting, has suffered the loss of two members:

John G. Greaves, M.D., died of cardiac decompensation on November 7, 1951. He received his M.D. degree from the University of Minnesota Medical School and additional postgraduate training at Rush Medical College. He practiced in Sherwood, North Dakota, from 1917 to 1927, and in Great Falls, Montana, from 1930 until his death. Dr. Greaves served as a Major in command of a field hospital in France during 1918-1919. His particular hobbies were hunting and fishing and he was very active in the Shrine groups. Professionally, Dr. Greaves served as President of the Cascade County Medical Society during 1938 and as President of the Montana Academy of Oto-Ophthalmology during 1940. He is survived by his wife, two sons, one of whom is a physician, and two daughters.

Richard R. Chapple, M.D., a native of Billings, Montana, died on November 24, 1951. He graduated in 1930 from the University of Michigan Medical School and after 4½ years of postgraduate training, began to practice in Montana. During World War II he served in the Medical Corps of the United States Army. He is survived by his wife and two daughters.

It is fitting that this House of Delegates stand for a moment in silence as a measure of respect and appreciation in memory of Dr. Greaves and Dr. Chapple.

The assembly stood in silent tribute to the memory of these former members.

This report was placed on file, there being no objection.

Albert W. Axley, M.D., Havre, Chairman of the Public Relations Committee, presented the following report:

Report of Public Relations Committee

The goals of this Committee and of other State Public Relations Committees for 1951 as outlined by the American Medical Association were as follows:

1. To make certain that every community has an adequate night and emergency call system.
2. To establish a State Grievance Committee to hear and settle complaints of patients.
3. To consciously develop better relations with the press and radio.
4. To encourage physicians to take a properly active role in various voluntary health campaigns.
5. To encourage and help the Woman's Auxiliary develop a strong organization with a constructive public relations program.

The goals of this Committee for the year 1952 are to implement those outlined above and to make every effort to accomplish the following:

1. To defeat the increasing socialistic trend in America.
2. To encourage component medical societies to police their own ranks and take appropriate disciplinary action against any members guilty of unprofessional and unethical conduct.
3. Tackle the PR problem involved in the cost of sickness.
4. To urge physicians to actively enter into community activities.
5. To unify efforts of individual physicians and the local medical societies to achieve common public relations goals.

It is our duty as physicians to be present and to work with other persons interested in the health of the pre-school and the school-age child. Physicians should encourage the establishment of local community health councils to consider and solve all local and school health problems. In those communities where there is a full-time public health officer, or even a part-time public health officer, these officials may accept many of the responsibilities for periodic health examinations of the school-age children. In some instances, however, part-time health officers and many of those in the community do not know or understand the duties and obligations of a public health department to the public and to the medical profession. This Committee has suggested that the Montana Medical Association develop a program to inform the public of the services it may expect to receive from public health departments.

Because of the apparent lack of statewide publicity about Association activities, this Committee has recommended that the Executive Secretary mail a copy of any releases to the Billings newspapers, to each member of the Public Relations Committee and that these committeemen accept the responsibility for publication of the news item in the newspaper in their own communities. This Committee has also agreed that the Executive Committee shall be authorized and encouraged to arrange for the broadcast of as many of the health education programs developed by the American Medical Association as possible.

Your Public Relations Committee deems it very desirable to establish a physicians' placement service so that all information about physicians seeking a location to practice medicine in Montana and about communities in need of medical services may be compiled in a central office. This Committee recommends that the President be empowered to appoint a special committee to develop and organize such a placement service in cooperation with the State Board of Medical Examiners.

The Public Relations Committee recommends that a system of night and emergency calls be established in all Montana communities through each component medical society and that these components make it known to the public by appropriate means that such service is available in time of emergencies.

The office of the American Medical Association has suggested to your Public Relations Committee that a number of subscriptions to "Today's Health" be purchased by the Association and presented to certain elected and appointed governmental officials. This will inform these representatives of the position of the medical profession on many of the controversial issues. This Committee recommends that subscriptions to this publication of the American Medical Association be entered by the Association and sent to the four Montana Congressmen, the Governor, the Superintendent of Public Instruction, the Attorney General and the president of each of the six university units.

It is also recommended by this Committee that every member of the Association purchase and display prominently in his office the plaque, "To My Patients," which has been prepared by the American Medical Association and is available through that office at $1.00.

There being no objection, this report was accepted and placed on file by President McPhail. The recommendations in the report were then considered separately. It was moved by Dr. Axley and seconded that the Montana Medical Association develop a program to inform the public about the services that it may expect to receive from local and district public health departments. This motion was seconded and carried. Dr. Axley then moved that the President of the Association be empowered to appoint a special committee to develop and organize a physicians' placement service in cooperation with the State Board of Medical Examiners. This motion was seconded and, after discussion, carried. It was moved by Dr. Axley and seconded that the Association purchase subscriptions to "Today's Health," published by the American Medical Association, to send to the two United States Senators from Montana and the two Representatives from Montana, the Governor, the Superintendent of Public Instruction, the Attorney General and the president of each of the six university units. Motion carried.

The Chairman of the Public Relations Committee, Dr. Axley, then presented the following supplemental report:

Supplemental Report

The Public Relations Committee on Thursday evening, February 28, held a meeting with the Mediation Committee of this Association. After considerable discussion it was agreed by the members of both of these committees that the following recommendations should be presented for consideration to the House of Delegates:

1. That the Public Relations Committee inform the citizens of Montana that the Montana Medical

Association recently established a Mediation Committee for the adjudication of written complaints of lay persons concerning professional services or professional conduct of any member of this Association.

2. That the public be informed to report any complaints against a physician to the Executive Secretary of the Montana Medical Association, 240 Stapleton Building, Billings, Montana.

3. That the Public Relations Committee be authorized to inform the public of these activities through press releases to various newspapers, provided such releases are approved by any three members of the Public Relations Committee and released to the newspapers through the Executive Office of the Association.

It was moved by George B. LeTellier, M.D., Lewistown, and seconded, that the recommendations included in the supplemental report of the Public Relations Committee be approved. During the discussion it was suggested that the recommendation to advise the public to address any complaints to the Executive Secretary be revised so that such complaints would be addressed to the Chairman of the Mediation Committee in care of the Executive Office of the Association. It was regularly moved and seconded that the motion be amended to so revise the recommendation of the Committee. This amendment was voted upon and carried, after which the original motion, as amended, was adopted.

T. R. Vye, M.D., Billings, presented the following report of the Legal Affairs and Malpractice Committee in the absence of the Chairman, Louis W. Allard, M.D.:

Legal Affairs and Malpractice

Your Committee on Legal Affairs and Malpractice has been very active since our report to the House of Delegates in September, 1951. We have continued our efforts to investigate, to the best of our ability, the individual cases that have been presented to us. We have been particularly interested in determining the basic causes behind these legal actions against the profession. The insuring agencies that carry the major portion of our malpractice insurance have not only been helpful and cooperative, but eager to assist us in working out this problem.

It is the purpose of this Committee to work with the insurance companies and their adjustors to determine the fairness of each case. To this end your Committee will assist the insuring companies in securing the best expert testimony pertinent to the particular case of any legal procedure. That your Committee can properly function, every member of this Association is requested to report as early as possible any threat along this line, not only to the insuring company, but also to this Committee directly or through our Executive Secretary, Mr. L. R. Hegland. It is much easier to handle these cases from the beginning than it is after actual papers have been filed.

We suggest that, for the benefit of the patient and his mental attitude toward his condition, that consultation be freely used, not only in serious cases, but in those cases where there might be some doubt lurking in the patient's mind.

We urge again that each physician provide himself with a copy of the several good books that have been published covering a physician's legal responsibility. Through our Executive Secretary we are sending to each of our members a copy of the report of Louis J. Regan, M.D., to the American Medical Association as this report, by a medico-legal expert, is quite comprehensive.

There being no objection, this report was ordered placed on file.

The following report of the Rheumatic Fever and Heart Committee was presented by Thomas W. Saam, M.D., Butte, in the absence of the Chairman, F. R. Schemm, M.D.:

Report of Heart Committee

Your Committee wishes to report that the Pilot Program in Cascade County is conducting regular clinics for diagnostic services upon referral by the physician. It is interesting to note that a number of patients are referred to the clinic by physicians in neighboring communities. In the course of the diagnostic procedures of the clinic it has been

They'd make quite a family reunion...

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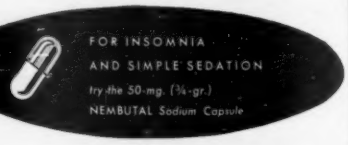

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Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm
Pylorospasm
Spasm of biliary tract
Spasm of colon
Peptic ulcer
Colitis
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.

Irritability Associated With Infections

Restlessness and Irritability With Pain

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia

SURGICAL
Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

PEDIATRIC Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Electroencephalography
Minor surgery

Preoperative Sedation

found that increased facilities are desirable if cases of congenital heart disease and of pure mitral stenosis are to be screened and proper recommendations made about operability. The possibility of obtaining these additional facilities is being explored by this Committee.

In cooperation with the State Board of Health the "Heart Bulletin" will be distributed to all members of the State Association and a series of extramural postgraduate courses in various Montana centers on heart disease is being arranged. These courses will be conducted by a well-known speaker and will be similar to those which have been sponsored for some years past by the Committee on Maternal and Child Welfare.

The Committee has no recommendations to present to the House at this session.

There being no objection, this report was placed on file.

Amos R. Little, M.D., Helena, Chairman of the Emergency Medical Service Committee, presented the following report:

Report on Emergency Medical Service

The role of the Montana Medical Association in the State Civil Defense Program is gradually being delineated and it now behooves each component medical society to assume certain basic obligations. Although civil defense is primarily the responsibility of the newly appointed civic officials, it is recognized that at time of disaster, whether it is atomic bombing or fire, flood, earthquake, or other disaster within the community, the physician is the first person to whom people are going to turn. It is important that each society at this time delegate specific responsibilities to individual members who will assume the lead in the programming and direction of the activities in cooperation with the local civil defense program. Specific analysis of the problem as it relates to Montana and its physicians at this time seems to indicate the following factors:

1. First-aid training is desired for the maximum number of individuals and it is within the realm of the physicians to stimulate the interest in this particular type of training.

2. Organization for casualty medical care will greatly expedite and facilitate such care when and if the need arises.

3. It would seem that the formation of clinical teams that are available to travel outside of the community, or to operate as groups within the community, must be considered and analyzed on a local basis. It is anticipated that, in the event of major calamities such as atomic bombing, or invasion, etc., of our West Coast neighbors, our Association will be requested to provide a given number of physicians who are able to move temporarily to the area of the catastrophy for emergency care and treatment. Each society should, therefore, consider the formation of such teams with the specific arrangements being coordinated through the office of the medical directors of civil defense.

4. A very pressing need is the analysis of existing hospital facilities and a study of how they can be utilized in the event of mass catastrophy. The planning for the sudden admission of from five to 5,000 or more critically injured patients must be accomplished. This, of course, will require complete utilization of existing facilities and the analysis of the most readily available improvised emergency facilities for rapid hospitalization. Each component society should select its director of medical activities for civil defense and coordinate the efforts of the society with the duly appointed civilian authorities and the officials in the division of health services under the State Civil Defense Director. By such coordination, both on a local and on a state level, much can be accomplished. The recognition by the societies of the problem that exists and the appointment of individuals who can be counted upon to assume the responsibility and then to actuate the plans as made is important.

Full information about the plans and the program of the Montana Civil Defense organization will be forwarded by this committee to all component societies.

There being no objection, this report was ordered placed on file.

In the absence of the Chairman of the Committee on Physicians-Schools Conference, Ray O. Bjork, M.D., Helena, the following report was read by Secretary Lindstrom:

Physician-Schools Conference

The Second Montana Conference on Physicians and Schools was held in Helena on October 5. This conference was attended by 196 individuals interested

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in the health of the school-age child from almost every community in the State. The conference was sponsored by the Montana Medical Association, the Montana State Dental Association, the Department of Public Instruction, the State Board of Health and the Auxiliary to the Montana Medical Association.

The program of the conference was as follows:

"What Happened at the 1950 Conference on Physicians and Schools," Clyde H. Fredrickson, M.D., Immediate Past President of the Montana Medical Association.

"The Purposes of the 1951 Conference on Physicians and Schools," F. L. McPhail, M.D., President, Montana Medical Association.

"Health Service Priorities," F. V. Hein, Ph.D., Consultant in Health Fitness, Bureau of Health Education of the American Medical Association.

Panel Discussions:

"Responsibilities of Practitioners of Medicine and Dentistry," George M. Donich, M.D., Leader.

"Responsibilities of Students," Mr. E. H. Fellbaum, Superintendent of Schools, Helena, Leader.

"Responsibilities of Parents," Mr. Lincoln J. Aikins, Registrar, Eastern Montana College of Education, Billings, Leader.

"Responsibilities of School Administrators," Mr. D. D. Cooper, President, Montana Education Association, and Superintendent of Schools, Townsend, Leader.

"Responsibilities of Public Health Personnel," Paul R. Ensign, M.D., Director, Child Health Services, State Board of Health, Leader.

It was voted that a similar conference be held in 1953.

There being no objection, this report was ordered placed on file by President McPhail.

The House of Delegates recessed at 12:30 p.m.

Second Meeting

The House of Delegates reconvened at the Placer Hotel, Helena, at 2:00 p.m.

The Chairman of the Maternal and Child Welfare Committee, E. L. Hall, M.D., read the following report:

Report on Maternal and Child Welfare

This Committee, at a meeting on October 6, 1951, agreed to present the following suggestions and recommendations to this House of Delegates:

1. That this Committee suggest the continuation of its regular detailed study of maternal deaths, using the new reporting form which has been developed by the Committee.

2. That this Committee advise the House of Delegates that the Subcommittee on Pediatrics plans to develop, approve and furnish adequate forms to conduct a detailed study of each infant death in the same manner as maternal deaths and that the study will begin as soon as the pediatric consultant is employed by the State Board of Health.

3. That this Committee has completed plans to sponsor, in cooperation with the State Board of Health, a postgraduate course on obstetrics and pediatrics during 1952. Current plans are to present such a course in part of the State during the spring and in the other part of the State during the fall.

4. That this Committee proposes to distribute to all physicians in Montana a brochure outlining important factors in the prevention and treatment of prematurity following the presentation of these postgraduate courses.

5. That this Committee recommend to the House of Delegates that the Montana Medical Association approve and encourage the use of public health nurses where available to implement educational programs on prenatal care in an effort to prevent maternal and infant deaths. It is the opinion of the Committee that these nurses may be able to render valuable assistance to the profession by urging expectant mothers to consult their physician regularly and frequently.

6. That this Committee advise the House of Delegates that, upon the recommendation and approval of the Subcommittee on Pediatrics, a series of twelve educational pamphlets entitled, "Pierre the Pellican," will be sent to mothers upon the birth of their first child, by the State Board of Health.

The Subcommittee on Obstetrics has reviewed the maternal deaths in Montana due to toxemia and members of the Committee have prepared a paper on this subject, which will be presented at the Scientific Session on March 1. In the near future this Subcommittee plans to forward to each Montana physician a brochure outlining in detail the classification, diagnosis and recommended treatment of toxemia in pregnancy.

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If refrigeration is not available in the home, or when mother and baby are traveling, Baker's Modified Milk *powder* is safe, easily dissolved and easy to use.

In the home, sufficient powder for each feeding may be measured into capped, clean, dry, sterile nursing bottles and warm, boiled water added at feeding time. When traveling, the bottles may be prepared at home, and the boiled water carried in a thermos bottle.

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There being no objection, this report was ordered placed on file by the President.

Following a discussion of some of the proposals of the Committee, R. Wynne Morris, M.D., Helena, moved that the recommendations of the Committee for an educational program to reduce and prevent maternal and infant deaths be approved by the House. This motion was seconded and carried.

Raymond E. Benson, M.D., Billings, Chairman of the Cancer Committee, read the following report:

Report of Cancer Committee

The Cancer Committee of this Association has been interested in the obligations assigned to it and has taken active steps toward fulfilling its assignments.

The Committee recognizes the desirability of increasing the facilities for doing Papanicolaou examinations in the state. The Committee felt that this could be done only through an increase in facilities and particularly by obtaining adequately trained technicians. The Committee has recommended that the American Cancer Society consider furnishing funds for training such technicians, upon the request of a recognized pathologist and approval by the local medical society. The American Cancer Society has considered this request and has acted favorably upon it. This Committee has insisted that any project for the training of technicians be done under the direction of a recognized pathologist. At the present time, one technician is already scheduled to go to the Memorial Hospital in New York for training under the sponsorship of the American Cancer Society and there will undoubtedly be others similarly trained in the future.

The Cancer Committee has formed subcommittees on cancer in each of the local medical societies throughout the state. At the present time twelve of the fourteen societies have formed committees. In the near future, it is hoped, every society in the State will have such a local Cancer Committee.

A Speakers' Bureau, composed of outstanding Montana physicians, is being formed. From this Speakers' Bureau, professional and lay groups may obtain a speaker on cancer or allied subjects. The traveling expenses of the speakers will be subsidized by the American Cancer Society. Arrangements for obtaining speakers from this bureau will be handled through the local Cancer Committee in the component societies.

The Cancer Committee has recommended and strongly urged that the Hospital Relations Committee, other interested committees and hospital administrators work for the improvement of endoscopic facilities in the hospitals of the State.

Dr. Pallister was appointed by the Chairman of the Committee to work with the State Board of Health in arranging for the forthcoming postgraduate lecture series on cancer in June.

The Cancer Committee approved the request for funds to aid a student in cancer research at Montana State University in Missoula. This recommendation of the Cancer Society was subsequently acted upon favorably by the American Cancer Society and a large grant has been given to this person. The State Cancer Committee has worked in close cooperation with the American Cancer Society and the State Board of Health.

There being no objection, this report was ordered placed on file by President McPhail.

The following report of the Mediation Committee was presented by the Chairman, F. S. Marks, M.D., Billings:

Report of Mediation Committee

To date the Mediation Committee has received two complaints from patients of members of this Association about professional services. One of these complaints has only recently been received and is still under consideration by the Committee. The other complaint has been reviewed and amicably concluded. It is the belief of a majority of the members of this Committee that, to a large extent, most of the information about the aims and purposes of this Committee should be related to the public by the individual physician. The Committee suggests that all physicians, when they encounter a dissatisfied patient, suggest that the patient contact the Mediation Committee and submit all pertinent information about the complaint. Such a procedure will be of value to the individual physician because he will not be required to commit himself on any particular situation where he may not know all the facts, and should be of great value in improving our public relations.

This Committee wishes to urge all physicians to

be extremely discreet in commenting about other physicians and methods of treatment.

There being no objection, this report was ordered placed on file by President McPhail.

H. V. Gibson, M.D., Great Falls, Chairman of the Tuberculosis Committee, presented the following report:

Report of Tuberculosis Committee

The Tuberculosis Committee of this Association submits the following review of its activities:

1. The Committee has cooperated closely with the Montana Tuberculosis Association. For the information of the delegates, the Tuberculosis Association plans to revise its Constitution and By-Laws and to submit it for adoption by the Association at its next Annual Meeting. This Committee suggests that this House of Delegates recommend to the Association that it include in its new By-Laws a provision for the continued representation of the Montana Medical Association upon its Executive Committee. In addition, the Committee suggests that this House of Delegates encourage the formation of a medical section of the Tuberculosis Association.

2. The Tuberculosis Committee proposes that the Legislative Committee of this Association study the advisability of presenting plans for appropriate legislation concerning institutional care for the non-resident tuberculous patient and for the recalcitrant contagious tuberculosis patient.

3. This Committee wishes to commend the Montana Division of the American Cancer Society and the Montana Tuberculosis Association to this House of Delegates for their very close cooperation in the chest x-ray screening programs. Both of these voluntary health agencies have been most cooperative and recognize the mutual benefits of such action.

4. This Committee encourages this House of Delegates to recognize the increasing advantage of the wide use of skin testing for tuberculosis, both in private practice and in public programs. This practice, the Committee feels, is of particular value in the younger age groups. Recent success in the treatment of tuberculosis indicates eradication of the disease and, therefore, intensive case-finding programs become increasingly necessary.

5. This Committee proposes that the House of Delegates consider approval of a program to permit chest x-rays of all patients admitted to hospitals. Such a program has proven a valuable means of case finding.

6. This Committee urges the House of Delegates to consider the advisability of encouraging pre-employment and regular examination for tuberculosis of all school personnel and suggests that the details of providing such examinations should be the concern of the employing agency.

7. This Committee specifically requests that the House of Delegates authorize it to undertake a study of the present practices of referrals of patients to private physicians for whom the Montana Tuberculosis Association has paid the x-ray fee. The objective of such a study will be to establish a statewide policy upon such referrals.

There being no objection, this report was ordered placed on file.

It was moved by John M. Nelson, M.D., Missoula, and seconded that the House of Delegates authorize the Tuberculosis Committee to undertake a study of the present practices on referral of those patients to private physicians whose chest x-ray fees have been paid for by the Montana Tuberculosis Association and that the Tuberculosis Committee present its recommendations to the House of Delegates at a subsequent meeting. Motion carried.

The Chairman of the Program Committee, Mary E. Martin, M.D., Billings, presented the following report:

Program Committee Report

The Program Committee has held no formal meetings, but has transacted its business through correspondence. The program of the scientific session of the Annual Meeting has been almost completely arranged; only two additional speakers are being sought.

Stephen N. Preston, M.D., Missoula, has been assigned the task of obtaining and publicizing the scientific exhibits of the Annual Meeting. Letters have been sent to each of the component societies

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and to all of the medical specialty groups inviting them to participate in this exhibit. To assist the Committee in stimulating interest in exhibits of a scientific nature, it has been suggested that an award be given by this Association to the scientific exhibit adjudged most interesting. This Committee recommends that the House of Delegates approve this proposal and appropriate not more than $25.00 for this purpose.

There being no objection, this report was ordered placed on file.

It was moved by Dr. Hurd and seconded that an appropriation of not more than $25.00 be made to the Program Committee for the purchase of an award to be presented to the individual who presents the most interesting scientific exhibit at the coming Annual Meeting. Motion carried.

Winfield S. Wilder, M.D., Great Falls, Chairman of the Mental Hygiene Committee, read the following report:

Committee on Mental Hygiene

Numerous requests have been received by the staffs of the mental hygiene clinics from physicians over the State regarding the present procedure for commitment of patients to the State Hospital at Warm Springs. It is the opinion of this Committee that it would be helpful if detailed instructions regarding the correct procedures for commitment were sent to all physicians in Montana. This Committee, therefore, plans to collaborate with the staffs of the mental hygiene clinics in making this information available.

Professor E. A. Atkinson, Head of the Department of Psychology at the University of Montana and Chairman of the Governor's Interim Committee on Mental Health, has informed your Chairman that his Committee is presently working on recommendations concerning the facilities at the State Hospital at Warm Springs and the State Training School at Boulder. Later they plan to present recommendations regarding the commitment laws of the State of Montana and indicate they will ask for assistance from this Committee. It is recommended that the Montana Medical Association go on record as supporting and approving the efforts and activities of the Governor's Interim Committee on Mental Health.

Another committee was recently appointed by the Governor to study and make recommendations regarding juvenile court legislation. This Committee is attempting to study all phases of juvenile delinquency as they pertain to more effective legislation. It is the recommendation of the Mental Hygiene Committee that the Montana Medical Association go on record as approving and supporting the work being done by the Governor's Committee on Juvenile Court Legislation.

This report was ordered placed on file, there being no objection.

Roger W. Clapp, M.D., Butte, moved the adoption of the following resolution:

WHEREAS, The Governor's Interim Committee on Mental Health is concerning itself with improvement of facilities for the care and treatment of patients at the State Hospital at Warm Springs and the State Training School at Boulder, and

WHEREAS, It plans to study and make recommendations regarding the commitment laws of Montana and will ask for assistance from the Mental Hygiene Committee of the Montana Medical Association, and

WHEREAS, The work of the Committee is aimed at more effective medical care for the citizens of Montana;

NOW, THEREFORE, BE IT RESOLVED, That the Montana Medical Association approve and support, in principle, the efforts and activities of the Governor's Interim Committee on Mental Health.

This motion was seconded and carried.

It was moved by Dr. Clapp that the following resolution be adopted:

WHEREAS, The Governor's Committee on Juvenile Court Legislation is concerned with providing more effective legislation for juvenile courts, and

WHEREAS, The purpose of this legislation is to provide for more effective prevention of juvenile delinquency and more effective treatment of the emotional problems underlying juvenile delinquency, and

WHEREAS, The Montana Medical Association is interested in health factors which will effectively combat juvenile delinquency:

NOW, THEREFORE, BE IT RESOLVED, That the Montana Medical Association approve and support, in principle, the efforts and activities of the Governor's Committee on Juvenile Court Legislation.

This motion was seconded and carried.

Eugene Hildebrand, M.D., Great Falls, Chairman of the Hospital Relations Committee, presented the following report:

Report on Hospital Relations

The Hospital Relations Committee has had no formal meetings so far this year but has conducted its business by correspondence.

Work has progressed on the clinical laboratory evaluation program. Each hospital in the State, together with their respective chiefs of staff, were sent a questionnaire and a letter explaining the program. They were asked if they performed certain laboratory procedures which lend themselves to evaluation, whether they wished to cooperate in the evaluation program and if they would be willing to aid financially to an extent not to exceed $2.00 per evaluation.

Fifty hospitals were contacted. Twenty-eight (56%) replied. Twenty-one of these twenty-eight signified their willingness to cooperate; five of the seven remaining do not operate laboratories and two refused. Four hospital laboratories wishing to cooperate stated that they would be unable to assist financially. In addition to the hospitals, two group clinics and one private laboratory are cooperating in the venture. The State Board of Health is cooperating in the serology evaluation.

Fifteen cooperating laboratories perform serology determinations. The first evaluation utilizing heated ACD plasma, packaged in ampules, has been sent to these laboratories. All results are not in as yet, but a report of the findings will be included in the annual report of the Committee.

The Committee feels that this important work should be continued. To further this end, the Committee feels that the Hospital Relations Committee should be made a standing committee of the Association.

There being no objection, this report was ordered placed on file by the President.

The Chair indicated that the Hospital Relations Committee be made a standing committee of this Association required an amendment to the By-Laws of the Association and should be presented as such if the House is to act upon it at this time. Since a special committee has been appointed to review and propose amendments to the By-Laws, it was suggested that the Hospitals Relations Committee refer this request to this committee rather than propose an amendment at this time. It was moved by Dr. Shillington and seconded, that the Treasurer be authorized to reimburse the Chairman of the Hospital Relations Committee in the amount of $37.07. Motion carried.

Dr. M. A. Shillington presented the following report of the Interprofessional Relations Committee:

Interprofessional Relations

There was given to this Committee a request from the Montana State Nurses Association that the doctors contribute financially to assist in a statewide survey of the nursing situation in Montana. The Nurses Association wished to raise a $2,000.00 budget for the purpose of this survey.

The members of this Committee considered the request. It was their individual opinion that the survey could serve no useful purpose. Similar surveys have been made in many states and the pattern is almost the same everywhere. The survey in Montana would not change the general pattern. The findings of this Committee were then presented to the Executive Committee, which concurred in our opinion.

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We then counseled with the Nurses Association and its Executive Secretary agreed with our findings. Although not speaking with authority for the entire group, she felt it would agree to discontinue plans for the survey.

There being no objection, this report was accepted and placed on file.

The following report of the State Chairman for the American Medical Education Foundation, Dr. Shillington, was read:

Medical Education Foundation

During the past few years the private practice of medicine as we know it has been under attack by the socialists who have made a determined attempt to change our present medical system. This attack was aimed at the outright socialization of medicine. With the aid of Whitaker and Baxter this attempt has temporarily been repulsed.

Another attack made on the medical profession was in the form of a subsidy offer to medical schools by the Federal Government. This offer has likewise temporarily been thwarted due to the assistance of many organizations and the farsightedness of a few influential Senators. The idea behind that which is to follow is to permanently relieve the medical schools of ever having to go to the Federal Government for financial assistance.

Convinced that an active program for additional financial support of medical schools would have to be undertaken, several groups began a serious study of means for raising funds for the support of medical education. These groups included leaders of the medical profession, medical educators, university presidents and outstanding public citizens. They joined together in the spring of 1949 to sponsor the establishment of the National Fund for Medical Education. The objective of this organization is to raise annually from the medical profession, business, industry, labor, agriculture and other groups, substantial funds for the unrestricted use of medical schools in support of their teaching program. The National Fund for Medical Education held its first meeting in 1949. Its Trustees are composed of distinguished leaders in American life with Past President Herbert Hoover serving as the Honorary Chairman. Mr. S. S. Colt, President of the Bankers' Trust Company of New York, is the active chairman. With a substantial nucleus of money from industry and life insurance companies, the Fund advanced to a point where it became desirable to plan a definite program for securing contributions from the medical profession. Consequently, the American Medical Association sponsored the establishment of the American Medical Education Foundation, a non-profit corporation. The purpose of this Foundation is to provide an instrument through which individual physicians in state and county medical societies and other professional organizations may make contributions to support medical education.

Now to give you an idea of the operation of this fund. Contributions from individual physicians may be earmarked for the medical college of the donor's choice or he may contribute to the general fund. All monies received from the American Medical Education Foundation are turned over to the National Fund for Medical Education and it is then distributed to medical schools as follows:

First, all money that had previously been earmarked for a specific school is paid directly to that school. The residue is then divided in the following manner, regardless of how much earmarked money a particular school received:

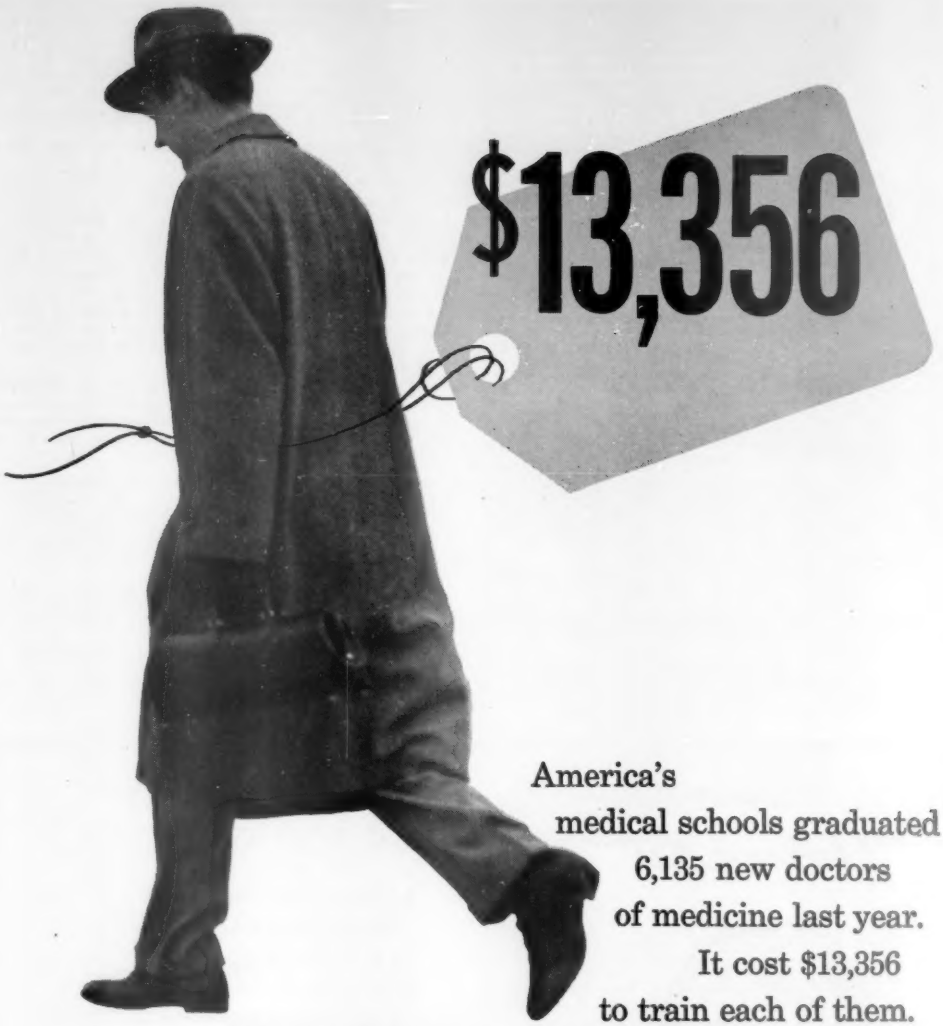
Grant A. A uniform annual sum granted to each accredited medical school.

Grant B. A uniform annual sum per student in each accredited medical school.

Grant C. Awarded to individual schools on the basis of special needs and problems.

There are no strings of any kind attached to these grants. The schools use the money as they see fit. In October, 1951, the deans of the medical colleges then assembled approved this method of fund-raising to help them meet their deficits.

The American Medical Education Foundation has tremendous appeal to the physicians of the United States. Where fund-raising has been spot-checked, the response has been excellent. The physician is encouraged to give by the knowledge that industry, business, labor and agriculture are joining in the program and, from all indications, are contributing at least three times as much as can ever be hoped to secure annually from physicians. Large corporations are encouraged in their philanthropy by the 5 per cent tax free deductions they are permitted to make from their earnings and excess profits. Mr. Beardsley Ruml has prepared a booklet for corporation comptrollers which, in some instances, shows that they are actually money ahead by making the donations up to the 5 per cent limit. Some



America's medical schools graduated 6,135 new doctors of medicine last year. It cost $13,356 to train each of them.

Most of this becomes medical school operating deficit which we as a profession must help meet. We will send your contribution along to the medical school of your choice if you prefer.

American Medical Education Foundation

535 North Dearborn Street, Chicago 10

of the large corporations, in making very substantial donations, have said that if the medical profession meets certain quotas they will then double their donations.

Last year the American medical schools graduated 6,135 new doctors. The cost per doctor was $13,356.00; yet during their four years of education if they paid a tuition of $3,356.00, which some of them didn't, there would still be a deficit of $10,000.00 per doctor. If each one of the graduates contributed $100.00 a year to the American Medical Education Foundation, it would take him one hundred years to pay back the $10,000.00 invested in him. Now, it is not anticipated that every physician will make an annual pledge of $100.00 per year; that would be wishful thinking. Instructors in medical schools, fellows in training, interns, physicians who have retired, in fact, a large number will be unable to contribute at all. From all indications, however, the physicians who are able to contribute, have responded beautifully. Many of them have pledged as much as $500.00 a year.

As physicians, you have many privileges which you have had to earn and must continue to justify. Raising millions of dollars for the American Medical Education Foundation cannot in any measure repay these obligations. Every physician in the country should, and many will, want to seize this opportunity to carry on the tradition of Hippocrates, "I will look upon him who shall have taught me this art even as one of my parents. I will share my substance with him and I will supply his necessity if he be in need."

A campaign will be conducted nationally during the months of April, May and June by the American Medical Foundation. Montana will play its part during this campaign. The annual quota to be raised by the physicians of Montana is $12,550.00. Your President is prepared to appoint a committee to expedite this campaign in Montana.

The last six months of 1952 are going to be used by the National Fund for Medical Education to canvass business, industry, labor, agriculture and other professions, all of which have indicated their willingness to contribute. If 1951 contributions are any indication, the Fund by December 31 will approach $6,000,000.

One more word about the Fund. Contributions of individual physicians are deductible from the net taxable income so long as his total contributions do not exceed 15 per cent of the taxable income. Every cent of money pledged by you, or by any organization, goes directly to the medical colleges. The entire cost for the American Medical Education Foundation is borne by the American Medical Association. The entire cost of the campaign for the National Fund for Medical Education is being contributed by one of the philanthropies whose name is withheld by request. There is not one cent of any contribution that is spent for administration.

This report was ordered placed on file, there being no objection.

Following a discussion it was moved by Dr. Shillington and seconded, that the House of Delegates approve, in principle, the participation of the Montana Medical Association in the fund-raising campaign of the American Medical Education Foundation and that it authorize the President to conduct this campaign to a satisfactory conclusion during the months of April, May and June, 1952, and each year thereafter so long as the Foundation exists. After some discussion this motion was carried.

President McPhail asked George A. Sextion, M.D., Great Falls, Chairman of the Resolutions Committee, to report. Dr. Sextion read the following resolution of appreciation to Dr. R. B. Robbins:

> BE IT RESOLVED, That this Association express its sincere appreciation to R. B. Robins, M.D., President-Elect of the American Academy of General Practice, Camden, Arkansas, who has so graciously given of his time and energy to be the guest speaker at our banquet and to present a radio broadcast.

It was moved by Harold W. Fuller, M.D., Great Falls, and seconded, that this resolution be adopted. Motion carried.

Dr. Sextion read the following resolution of appreciation to those individuals and groups that had contributed to the success of this Interim Session:

BE IT RESOLVED, That the House of Delegates of the Montana Medical Association express its sincere thanks to the officers and members of the Lewis & Clark County Medical Association, to James M. Flinn, M.D., Chairman of the Local Arrangements Committee, and to his committee members for the time and effort expended in arranging this session and for the exceptional hospitality, cordial fellowship and magnificent entertainment provided for the members of this Association.

It was moved by Dr. C. F. Little and seconded, that this resolution be adopted. Motion carried unanimously.

Dr. Sexton read the following resolution endorsing the bills in Congress declaring a half-holiday on election day:

BE IT RESOLVED, That the House of Delegates of the Montana Medical Association endorse and support Concurrent Resolution 176 in the United States Congress to declare a legal half-holiday on the day of the National elections.

It was moved by Dr. Brewer and seconded, that this resolution be adopted. Motion carried.

The following resolution expressing opposition to a system of free hospitalization for the aged and certain dependent groups was read by Dr. Sexton:

WHEREAS, Oscar Ewing, Federal Security Administrator, has proposed a system of free hospitalization for the aged and certain dependent groups, and

WRHEREAS, All persons 65 and over and their dependents who are entitled to Social Security cash benefits, regardless of whether they actually are receiving the benefits, would be eligible for 60 days of free hospital service in any one year, and

WHEREAS, Adoption of such a system would bring about a form of federal subsidy and control of hospitals and socialize hospital care for a large percentage of rapidly increasing aging population of the United States, and

WHEREAS, Socialized hospital care would constitute another decisive step towards the achievement of socialized medicine with its inevitable inferior quality of medical care;

THEREFORE, BE IT RESOLVED, That we, the members of the House of Delegates of the Montana Medical Association in regular session assembled this 29th day of February, 1952, go on record as opposing the plan of free hospitalization; and

BE IT FURTHER RESOLVED, That a copy of this resolution be spread upon the minutes of this meeting and that copies of it be sent to members of Congress and to the American Medical Association.

It was moved by Dr. Roberts and seconded, that this resolution be adopted. Motion carried.

Dr. Sexton read the following resolution in opposition to Universal Military Training:

WHEREAS, All previous wars and emergencies of this nation have been adequately met by conscription, and

WHEREAS, Universal Military Training as proposed by pending legislation also conscripts people for civil positions in time of peace, and

WHEREAS, Such legislation is a return to government controls, regimentation and taxation, and has led to degeneration and destruction of nations that have previously enacted similar laws, and

WHEREAS, Such legislation would either interrupt or cause constant fear of interruption of the routine plans of all male citizens for several years thus making it difficult or impossible for them to make definite life plans, and

WHEREAS, This law within a few years would make the Federal Government responsible for the medical care of more than 50 per cent of the male population of the United States under the present Veterans' Program, and

WHEREAS, Such a law would place an increased burden upon the already heavily taxed citizens of this country;

THEREFORE, BE IT RESOLVED, That the House of Delegates of the Montana Medical Association is unalterably opposed to Universal Military Training, and

BE IT FURTHER RESOLVED, That a copy of this resolution be spread upon the minutes of this meeting and that copies be sent to members of Congress and to the American Medical Association, and

BE IT FURTHER RESOLVED, That the House of Delegates of the Montana Medical Association go on record as being opposed to this or any other similar legislation and that the Executive Committee be instructed to take such steps as may be necessary to implement this resolution.

It was moved by Dr. Hurd and seconded, that this resolution be adopted. After a discussion of the resolution by several of the delegates, it was moved by Dr. Donich that the resolution be amended to read that this House of Delegates is "unalterably opposed to the bills on Universal Military Training now being considered by the Congress," rather than "unalterably opposed to Universal Military Training." This motion to amend the resolution was voted upon and car-

ried. The original motion to adopt the resolution on Universal Military Training was then voted upon and the resolution was adopted as amended.

Dr. Peterson, Butte, discussed the various proposals that had been considered by the House of Delegates of the American Medical Association relative to medical and hospital care for veterans. He indicated that the Veterans' Administration Act should probably be clarified by the United States Congress. He presented the following resolution for consideration by the House and moved its adoption:

WHEREAS, The members of this Association are in full agreement that Veterans should receive the highest quality of medical and hospital care for service-connected disabilities, and

WHEREAS, The present Veterans' Administration Act permits medical treatment of veterans with non-service connected disabilities by the Veterans' Administration:

THEREFORE, BE IT RESOLVED, That we, the members of the House of Delegates of the Montana Medical Association, in regular session assembled this 29th day of February, 1952, urge the Congress of the United States to clarify the statement in the present Veterans' Administration Act admitting veterans to Veterans' Administration Hospitals upon certification of a statement that they are unable to pay for hospital and medical care and that the Veterans' Administration be empowered to investigate such claims of veterans to determine their actual financial status, and

BE IT FURTHER RESOLVED, That a copy of this resolution be spread upon the minutes of this meeting and that copies of it be sent to members of Congress and to the American Medical Association.

This motion was seconded and, after a short discussion, carried.

George G. Sale, M.D., Delegate of the Western Montana Medical Society, discussed the Public Health League of Montana and its publication, "Montana Health." As a representative of the Montana Academy of Oto-Ophthalmology, he stated that while he did not have any particular motion or resolution to present upon this subject, he wished to register, on behalf of the Academy, its objection to contributions by the Medical Association supporting the publication of a health magazine which is not always edited by a physician. During a limited discussion of these comments it was pointed out by Secretary Lindstrom that almost every voluntary health organization in Montana, and the majority of the members of these organizations, contributed to the activities of the Public Health League of Montana.

There being no further business, the House of Delegates adjourned sine die at 3:20 p.m.

The following delegates and alternates attended the sessions of the House of Delegates:

Cascade County: J. J. Bulger, Great Falls; H. W. Fuller, Great Falls; Eugene Hildebrand, Great Falls; F. D. Hurd, Great Falls; C. F. Little, Great Falls; W. J. Roberts, Great Falls; W. E. Sullens, Great Falls.

Fergus County: P. J. Gans, Lewistown; G. B. LeTellier, Lewistown; J. A. Mueller, Lewistown.

Hill County: A. W. Axley, Havre; R. H. Leeds, Chinook; J. J. Wier, Big Sandy.

Lewis & Clark County: W. F. Cashmore, Helena; A. R. Little, Helena; R. W. Morris, Helena.

Mount Powell: G. M. Donich, Anaconda.

North-Central Montana: R. J. Casey, Conrad; G. D. Waller, Cut Bank.

Park-Sweetgrass: W. E. Harris, Livingston; G. J. Moffitt, Livingston.

Silver Bow County: H. L. Casebeer, Butte; R. W. Clapp, Butte; M. A. Gold, Butte; R. F. Peterson, Butte; T. W. Saam, Butte; H. A. Stanchfield, Dillon.

Southeastern Montana: J. E. Low, Sidney; S. C. Pratt, Miles City; M. A. Shillington, Glendive.

Western Montana: C. H. Fredrickson, Missoula; L. W. Brewer, Missoula; W. E. Harris, Missoula; J. M. Nelson, Missoula; G. G. Sale, Missoula; P. W. Willis, Hamilton.

Yellowstone Valley: R. E. Benson, Billings; J. H. Bridenbaugh, Billings; D. E. Hodges, Billings; F. S. Marks, Billings; L. G. Russell, Billings; J. A. Shaw, Billings; P. J. Sullivan, Billings; O. C. Rathman, Billings; Maude Gerdes, Billings.

UTAH
State Medical Association

Obituary

VIVIAN PARLEY WHITE

Dr. Vivian P. White, Immediate Past President of the Utah State Medical Association, died Tuesday, May 13, 1952, after a two months' illness.

Dr. White graduated from the Harvard Medical School in 1923. He did postgraduate work at the University of Vienna in 1924 and 1925. He took postgraduate work under Dr. A. Fuchs at the University of Vienna in 1931 and for six months as an assistant to Professor Imre at the University of Budapest in 1932. During the same year he studied cataract surgery at the Moga Hospital, Punjab, India.

Dr. White was a member of the staff of the Salt Lake General Hospital, Lecturer in Surgery at the University of Utah Medical School and a Past President of the Utah State Ophthalmological Society. He held membership in the Pacific Coast Oto-Ophthalmological Society and the Los Angeles Research Study Club. He was a member of the Utah State Medical Association, the Salt Lake County Medical Society and the American Medical Association. He was certified by the American Board of Oto-Laryngology and was a member of American Academy of Ophthalmology and Oto-Laryngology.

Dr. White was an active member of the Church of Jesus Christ of Latter-Day Saints, having served a mission for that church from 1916 to 1919.

Dr. White is survived by his widow, two sons, a brother and a granddaughter and his parents.

Auxiliary

REPORT OF THE UTAH STATE MEDICAL AUXILIARY FOR MAY

The Executive Board of the State Auxiliary met on April 23 in the State Medical offices in Salt Lake City, with the President, Mrs. J. Russel Smith of Provo, in the chair. Twenty-three officers and board members were present.

The committee, with Mrs. Owen P. Henninger as Chairman, presented the new Constitution. Copies of the same had been previously sent to the various County Auxiliaries for reading and discussion. Other committee chairmen presented their reports.

Whitaker and Baxter's report on the stand of the various candidates for President of the United States in regard to socialized medicine was given, and it was suggested that as soon as a more complete report comes in from the Chicago office that the doctors' wives get complete information as to the stand of the candidates, and begin their work in their own local communities.

It was reported that two of our members have passed away since last year—Mrs. Garland Pace of Salt Lake City and Mrs. A. J. Hagen of Provo, Utah.

Elections have been held in most of the County Auxiliaries. Salt Lake County held its installation on April 22 at the Salt Lake Country Club.

The following were elected: Mrs. A. W. Middleton, President; Mrs. Dean Moffat, First Vice President; Mrs. George Soffe, Second Vice President; Mrs. Grant Hughes, Recording Secretary; Mrs. James F. Orme, Corresponding Secretary; Mrs. F. Heber Kimball, Treasurer; Mrs. Robert Snow, Historian.

Utah County held its election on March 3, and those elected to serve were installed on April 23. The new officers are: Mrs. Milo Moody of Spanish Fork, President-elect; Mrs. James H. Quinn, Provo, First Vice President; Mrs. Boyd J. Larson, Lehi, Secretary; Mrs. Norman Parker, Springville, Treasurer. Mrs. Eugene Weimers of Provo, new President, was elected last year.

All Auxiliaries in the state have been active throughout the entire year in nurse recruitment, health problems of the state, civil defense, Red Cross, Today's Health magazine, and many other things. Plans are being formulated for the fall elections, insofar as they effect medicine and medical practices.

Following the board meeting, the ladies were guests of Dr. Bowers, Dean of the Utah State Medical School; Dr. Harden Branch and Dr. Taboroff of the Child Guidance Center, and the Psychiatric Department of the County Hospital. Luncheon was served in the main dining room, with short talks by the host doctors; a tour through the buildings followed.

MRS. CLAUDE L. SHIELDS,
Press and Publicity Chairman.

UTAH
Medical School Notes

On May 1, Dr. John Z. Bowers, Dean of the University of Utah College of Medicine, began a leave of absence of about two months to serve as a consultant on health education to the Ford Foundation. Dr. Bowers will spend this period in India to evaluate health and medical problems in the villages of that country and to determine the feasibility of a program for health education.

Dr. M. M. Wintrobe, Professor and Head of the Department of Medicine at the University of Utah, has been accorded a distinct honor in that he has been named Chairman of the Advisory Council of the Life Insurance Medical Research Fund for 1952-53.

Dr. Don H. Nelson, Instructor in the Department of Biochemistry, recently took an active part in the Ciba Conference in London, England. He presented some of the results of his work on adrenal steroid levels in the blood after epinephrine, cortisone and Compound F injections.

Dr. Stewart Harvey, Assistant Professor of Pharmacology, University of Utah, is one of twenty-one young American scientists to receive five-year scholarship grants from the John and Mary R. Markle Foundation. The grant is made directly to the medical school at the rate of

$6,000 a year for five years in support of the recipient and his research.

Dr. Glen R. Leymaster, Professor and Head of the Department of Public Health and Preventive Medicine, has recently returned from a trip sponsored by the Rockefeller Foundation for the study of out-patient medical training in the various schools and clinics of the country. The results of Dr. Leymaster's study will be made available to medical schools throughout the United States.

COLORADO
State Medical Society

Obituary

DELBERT L. WHITTAKER

Dr. Delbert L. Whittaker passed away in his sleep, of coronary heart disease, on December 30, 1951, at his home in Hayden, Colorado.

He was born at Tarkio, Missouri, on January 10, 1878. He spent his early life in Missouri, coming to Colorado to take his medical training at the University of Colorado, where he was graduated in 1905. He interned at Mercy Hospital. Following his internship in 1906 he practiced at Johnstown until 1914, when he moved to Routt County.

He was the first physician and surgeon for the Colorado & Utah Coal Company, at Mt. Harris, Colorado. He moved to Hayden in 1920, where he continued to practice at Mt. Harris and Hayden until 1937, at which time he was forced to retire on account of his health.

Dr. Whittaker took a very active part in the establishment and maintenance of the Solandt Memorial Hospital, of Hayden, and was also active in the other civic activities while he was practicing. He was a member of the Masonic lodge and an Emeritus Member of the Colorado State Medical Society.

He is survived by his widow, Doris A. Whittaker; a daughter, Mrs. Glenn Stukey, and two grandchildren.

COLORADO
Medical School Notes

DIAGNOSIS IN INTERNAL MEDICINE WITH EMPHASIS ON PHYSICAL DIAGNOSIS

July 21-25, 1952

Director: James J. Waring, M.D.

Apply: Office of Graduate Medical Education
4200 East Ninth Avenue, Denver, Colorado

Faculty for Course

Guest Faculty: Richard J. Bing, M.D., Professor of Experimental Medicine, Medical College of Alabama, Birmingham, Alabama; Arthur C. Curtis, M.D., Professor of Dermatology and Syphilology, University of Michigan Medical School; Richard H. Freyberg, M.D., Associate Professor of Clinical Medicine, Cornell Medical College; Louis N. Katz, M.D., Director of Cardiovascular Research, Michael Reese Hospital, Chicago; Walter L. Palmer, M.D., Professor of Medicine, University of Chicago School of Medicine.

Faculty — University of Colorado School of Medicine: Leighton L. Anderson, M.D., Assistant

Professor of Medicine; John W. Berry, M.D., Associate Professor of Medicine; S. Gilbert Blount, M.D., Assistant Professor of Medicine; Ward Darley, M.D., Dean, Department of Medicine; Col. Edwin M. Goyette, M.C., Clinical Instructor in Medicine; Raymond R. Lanier, Ph.D., M.D., Professor and Head of the Department of Radiology; Morris Levine, M.D., Associate Clinical Professor of Radiology; John A. Lichty, M.D., Associate Professor of Pediatrics; Hope Lowry, M.D., Assistant Professor of Medicine; Malcolm C. McCord, M.D., Fellow in Medicine; Gordon Meiklejohn, M.D., Professor and Head of the Department of Medicine; R. Wayne Moody, M.D., Assistant Clinical Professor of Medicine; Mason Morfit, M.D., Assistant Clinical Professor of Surgery and Head of the Division of Oncology; Mordant E. Peck, M.D., Assistant Professor of Surgery; Abe Ravin, M.D., Associate Clinical Professor of Medicine; G. Milton Shy, M.D., Assistant Professor of Neurology; Henry Swan, II, M.D., Professor and Head of the Department of Surgery; Atha Thomas, M.D., Associate Clinical Professor and Head of the Division of Orthopedic Surgery; Col. Carl W. Temple, MC., Assistant Clinical Professor of Medicine; James J. Waring, M.D., Professor of Medicine.

MONDAY, JULY 21

Morning Session

8:00- 8:45—Registration — University of Colorado Medical Center, 4200 East Ninth Avenue, Denver, Colorado.

8:45- 9:00—Welcoming Address—Ward Darley, M.D., Director, Medical Center.

9:00- 9:30—Moving picture on Physical Diagnosis, prepared by Gordon Myers, M.D., Detroit, Michigan.

9:30-10:30—"Facial and Ocular Involvements in Neurologic Disorders"—G. Milton Shy, M.D.

10:30-10:50—Discussion and Intermission.

10:50-11:50—"Tumors of Head and Neck"—Mason Morfit, M.D.

11:50-12:00—Discussion.

12:00-12:30—Moving picture of Breast Tumors.

12:30- 1:30—Lunch.

Afternoon Session

1:30- 3:30—"Neurologic and Muscular Disorders"—G. Milton Shy, M.D.

1. Technic of the Neurologic Examination.
2. Clinic and Demonstration of Disorders Affecting: (a) Upper extremities, (b) Lower extremities.

A clinic covering characteristic signs and symptoms of the following disorders: Tabes, paresis, amyotrophic lateral sclerosis, multiple sclerosis, cerebral palsy, hemiplegia, poliomyelitis, Friedreich's ataxia, progressive muscular dystrophy, dystrophia myotonica, myastenia gravis, chorea.

3:30- 4:00—Discussion and Intermission.

4:00- 4:50—"Pediatric Physical Diagnosis" — John A. Lichty, M.D.

4:50- 5:30—"X-ray Demonstration" — Raymond R. Lanier, Ph.D., M.D.

TUESDAY, JULY 22

Morning Session

8:00- 9:00—"Diagnosis and Treatment of Acute and Chronic Pericarditis"—Col. Edwin M. Goyette, M.C.

9:00-10:00—"Essentials of Electrocardiography" —Abe Ravin, M.D.

10:00-10:15—Intermission.

10:15-11:15—"The Coronary Circulation in Health and Disease"—Richard J. Bing, M.D.

11:15-12:15—"Angina Pectoris and Myocardial Infarction"—John W. Berry, M.D.

12:15-12:30—Discussion.

12:30- 1:30—Lunch.

Afternoon Session

1:30- 4:30—Clinic on Congenital Heart Disease —Henry Swan, II, M.D.; S. Gilbert Blount, M.D.; Malcolm C. McCord, M.D.

1. Pulmonic Valvular Stenosis With and Without Patency of the Foramen Ovale.
2. Tetralogy of Fallot.
3. Atrial Septal Defect.
4. Patent Ductus Arteriosus.
5. Coarctation of the Aorta.

The five anomalies named above will be covered completely. Patients with these various entities will be presented. The characteristic and diagnostic features of the history, physical examination, electrocardiogram and fluoroscopy will be emphasized. Catheterization data and the angiocardiograms in all these anomalies will be demonstrated and discussed. Surgical treatment in all these states will be discussed and patients benefited by surgery will be presented.

4:30- 5:30—Discussion—Richard J. Bing, M.D.

Tuesday Evening

Dinner at the Denver Country Club
Louis N. Katz, M.D.

WEDNESDAY, JULY 23

Morning Session

8:00- 8:30—"Physiologic Bases for the Characteristic Physical Findings in Valvular Heart Disease"—John W. Berry, M.D.

1. Physical basis for murmurs.
2. Characteristics of murmurs.
3. Indirect evidence of valvular defects, e.g., liver pulsation, Corrigan's pulse.

8:30- 9:00—"Physiologic Basis for Characteristic Physical Findings in Cardiac Arrhythmias and Certain Other Non-Valvular Forms of Heart Disease"—Hope Lowry, M.D.

9:00- 9:30—"Symptoms of Congestive Heart Failure"—Louis N. Katz, M.D.

9:30-10:00—Discussion and Intermission.

10:00-12:30—Demonstration of Patients With Cardiac Lesions—Individual Demonstration of Patients by: Louis N. Katz, M.D.; John W. Berry, M.D.; R. Wayne Moody, M.D.; Hope Lowry, M.D.; S. Gilbert Blount, M.D.

12:30- 1:30—Lunch.

Afternoon Session

1:30- 2:45—Panel Discussion of Cardiac Problems—James J. Waring, M.D., Moderator; Louis N. Katz, M.D.; Richard J. Bing, M.D.; John W. Berry, M.D.; S. Gilbert Blount, M.D.

2:45- 3:00—Intermission.

3:00- 4:30—1. Individual Demonstration and Instruction in Cardiac Fluoroscopy—John W.

Berry, M.D.; Hope Lowry, M.D.; Leighton L. Anderson, M.D.; S. Gilbert Blount, M.D. 2. Exhibit of Mitral Valvulotomy—Abe Ravin, M.D.; S. Gilbert Blount, M.D.

4:30- 5:30—Demonstration of Cardiac X-rays and Correlation of X-rays and Clinical Features—Raymond R. Lanier, Ph.D., M.D.

THURSDAY, JULY 24

Morning Session

8:00- 9:45—Clinic on the Common Skin Disorders—Arthur C. Curtis, M.D., and Staff of the Department of Dermatology.

10:00-11:30—I. "Preoperative Diagnosis of Acute and Chronic Abdominal Conditions"—Presentation of Cases: Walter L. Palmer, M.D.

11:30-12:30—"Recent Advances in the Treatment of Arthritis"—Richard H. Freyberg, M.D.

12:30- 1:30—Lunch.

Afternoon Session

1:30- 2:30—II. "Preoperative Diagnosis of Acute and Chronic Abdominal Conditions"—Walter L. Palmer, M.D.

2:30- 3:30—"Diagnosis and Treatment of Venereal Diseases"—Arthur C. Curtis, M.D.

3:30- 4:00—Discussion.

4:00- 5:00—X-ray Demonstration — Morris Levine, M.D.

FRIDAY, JULY 25

Morning Session

8:00- 9:00—"Orthopedic Clinic for the General Practitioner"—Atha Thomas, M.D.

9:00-10:00—"Vascular Disorders of the Extremities"—Case Demonstration: Leighton L. Anderson, M.D.; Mordant E. Peck, M.D.

10:00-10:15—Intermission.

10:15-11:00—"A Review of Hypertension"—Richard J. Bing, M.D.

11:00-12:00—"Recent Advances in Virus Diseases"—Gordon Meiklejohn, M.D.

12:00- 1:00—Lunch.

Afternoon Session

1:30- 3:30—"Differential Diagnosis of Arthritis"—Case Demonstration: Richard H. Freyberg, M.D.

3:30- 3:45—Intermission.

3:45- 4:15—"Differential Diagnosis of Pulmonary Lesions"—Col. Carl W. Tempel, M.C.

4:15- 5:00—X-ray Demonstration — Morris Levine, M.D.

General Information

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Tuberculosis Abstracts

Issued Monthly by the National Tuberculosis Association

Vol. XXV JUNE, 1952 No. 6

DELAYS IN THE DIAGNOSIS OF TUBERCULOSIS FROM THE INCAUTIOUS USE OF ANTIBIOTICS

By William H. Oatway, Jr., M.D., Arizona Medicine, July, 1951.

It was noted recently that case histories of newly admitted patients to a California sanatorium mentioned the use of penicillin and other drugs for supposedly non-tuberculous conditions. This often happened without any attempt to exclude or make a diagnosis of tuberculosis. It was decided to recheck such information by requestioning the patients. The results were amazing.

Forty per cent of the fifty patients in residence on February 15, 1951, had suffered to some degree from the "blind" use of chemotherapy.

A—Chemotherapy Without Examination for Tuberculosis.

1. A woman, age 25. "Cold" with pleurisy, treated with *sulfadiazine* and *penicillin*. Hemoptysis caused patient to insist on an x-ray. Far advanced exudative lesion found with cavity. (Delay—two months.)

2. A woman, age 26. "Bad cold" treated with *penicillin* and *aureomycin*. Diagnosis by survey film. Far advanced exudative lesion with cavity. (Delay — two months.)

3. A woman, age 26. "Bronchial trouble" with asthma, then "pleurisy" for one year. *Penicillin* inhalations. Diagnosis made with gastric culture. X-ray shows a subminimal lesion. (Delay—one to two years.)

4. A woman, age 29. "Virus infection" treated with *penicillin*. Diagnosis made by chance survey film of moderately advanced exudative disease with cavity. (Delay —two weeks.)

5. A man, age 22. "Pneumonia" with asthma, diagnosed without x-ray. Treated with *penicillin*. Diagnosed by survey film which showed scattered exudative patches with numerous small cavities. (Delay—possibly two years.)

6. A woman, age 69. "Virus pneumonia" diagnosed without x-ray. *Penicillin* given. Diagnosis by survey film later; moderately advanced lesion. (Delay — six months.)

7. A woman, age 38. "Bad cold" treated with *penicillin*. X-ray was not made until a survey film was taken, three months and two doctors later. Lesion moderately advanced. (Delay—six weeks.)

8. A woman, age 36. "Colds" then "pleurisy." Therapy with *chloromycetin* for one week. Survey film showed far advanced disease with cavity. (Delay—one to three months.)

B—Chemotherapy With the Tuberculosis Lesion Misinterpreted.

1. A man, age 46. "Bad cold" treated with *penicillin* injections and inhalations. X-ray showed patchy lesions. No further study was made. Survey film showed slight increase in moderately advanced tuberculosis. (Delay—18 months.)

2. A woman, age 45. After accident an effusion from trauma was noted, plus a patchy lung lesion. No other diagnosis made. "Virus pneumonia" the next winter treated with *streptomycin* because of sensitivity to *penicillin*. A persistent fever forced a diagnosis of far advanced tuberculosis with atelectasis and cavity. (Delay —two years.)

3. A woman, age 54. "Lobar pneumonia." No x-ray, but "sulfa" given. Recurrent "Virus X" bronchitis three years ago. Fluoroscopy done occasionally. *Penicillin* and *aureomycin* used. Patient continued to work as a nurse. X-rays now show far advanced disease with a large cavity and bronchogenic spreads. (Delay—three to six years.)

4. A woman, age 39. "Virus infection" treated with "sulfa," later with *penicillin*, then with *terramycin*. Survey film read as negative. Pleural effusion with tubercle bacilli found. Earlier films reviewed and seen to contain minimal lesion. (Delay — four to five months.)

C—Chemotherapy in Known But Forgotten Cases of Tuberculosis.

1. A woman, age 27. Tuberculosis known for eight years, but called inactive. "Flu." *Penicillin*, *aureomycin*, and *terramycin* were tried. A pleural effusion resulted in the diagnosis of tuberculosis activity. (Delay—one month.)

2. A man, age 36. Tuberculosis known for four years, considered to be arrested. Overwork and strain followed by "intestinal flu." Hemoptysis resulted in a diagnosis of exudative and cavitative disease. (Delay—six weeks.)

3. A man, age 44. Tuberculosis known for ten years. A "cold" and several "sore throats." *Penicillin* therapy used, but stopped because of reactions. An active far-advanced tuberculosis was diagnosed by x-ray later in the year. (Delay—six months.)

4. A woman, age 42. Tuberculosis known for ten years. "Virus flu" treated with *aureomycin*, was followed by hemoptysis. Diagnosis of active far-advanced tuberculosis. (Delay—one year.)

5. A man, age 38. Tuberculosis fourteen years ago. Limited service in the Army Medical Corps. Life insurance x-rays read as negative. A "cold" with bronchitis. *Penicillin*, then *aureomycin*. X-ray showed bilateral far-advanced exudative tuberculosis with new cavitation. (Delay—two to four months.)

6. A man, age 46. Tuberculosis known six years ago when a "strep throat," treated with *sulfadiazine*, relapsed and the lung disease was recognized, treated and arrested. A year ago he had bronchitis. Rest and antibiotic pills used. Moderately advanced tuberculosis finally diagnosed. (Delay—two to twelve months.)

7. A man, age 45. Tuberculosis treated ten years ago, and observed since by x-ray. For past year *sulfadiazine* and *penicillin* were used repeatedly for "bronchiectasis." No sputum examination. Sent to sanatorium with far-advanced fibrocavernous disease. (Delay—one year.)

8. A woman, age 52. Tuberculosis was known fourteen years ago and treated for four years. A "virus" infection two months ago was accompanied by fever, chills, etc. Therapy was *penicillin*, *chloromycetin* and *aureomycin*, but no x-ray was taken. She returned to work as a nurse, *in the nursery of a hospital*. An x-ray showed far-advanced disease with a 10 cm. cavity. (Delay—two months.)

Chemotherapy for lung infections may be hazardous if tuberculosis is not ruled out as a cause of the symptoms. Twenty patients in a sanatorium of fifty beds have had an appreciable delay in the diagnosis of tuberculous activity because of the use of chemotherapy and the lack of x-rays, bacterial studies, and clear thinking. The newer antibiotics give a false sense of security because of their broad field of action. The drugs are efficient and attractive, but they must be aimed more precisely at specific and vulnerable infections. The physician and patient both seem to be responsible for the delay in diagnosis. Persons who have had tuberculosis are especially at fault if they do not check on the cause of lung symptoms. A chest x-ray survey has helped some of the present patients to a diagnosis. It would be valuable to have inexpensive case-finding facilities available, and physicians would be wise to use them.

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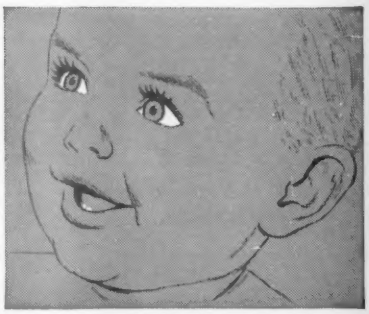
*Frost, L. H., and Jackson, R. L.: Growth and Development of Infants Receiving a Proprietary Preparation of Evaporated Milk with Dextri-Maltose and Vitamin D, J. Pediat. 39:585-592 (Nov.) 1951.



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